

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 - should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14685

CERTIFICATE OF DEATH

16196

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VA. b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN TB 19 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS RT. 1, RIDGELEY, W.VA. 85-3	
3. NAME OF DECEASED (Type or print) First GARNET Middle W Last ARBOGAST		4. DATE OF DEATH Month NOV. Day 28 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH WXXX.3-25-03
9. AGE (In years last birthday) yrs. 64		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (County & State, or foreign country) W. VIRGINIA Bowden		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. W. ARBOGAST		14. MOTHER'S MAIDEN NAME RUTH COBERLY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 705-10-8562	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PLEURAL EFFUSION WITH METASTASIS DUE TO (b) PULMONARY METASTASIS, LYMPHATIC, BILAT. DUE TO (c) SARCOMA OF STOMACH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 151X			INTERVAL BETWEEN ONSET AND DEATH 14 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-8-1967 to 11-27-1967 , that (I) (we) last saw the deceased alive on 11-27-1967 , and that death occurred at 2:20P M, from causes and on the date stated above			
22a. SIGNATURE Richard Schindler		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. RICHARD SCHINDLER		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec.1, 1967	23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park	23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DEC 7 1967	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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1M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14686

14687

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN TB 20 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 186 MAIN ST.	
3. NAME OF DECEASED (Type or print) First JAMES Middle C Last ARRINGTON		4. DATE OF DEATH Month NOVEMBER Day 27 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-15-1884
9. AGE (In years 100 birthday) yrs. 83		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - WESTERN MARYLAND RAILROAD		11. BIRTHPLACE (County & State, or foreign country) GLADE HILL, VIRGINIA	
12. CITIZEN OF WHAT COUNTRY U. S. A.		13. FATHER'S NAME HARRY W. ARRINGTON	
14. MOTHER'S MAIDEN NAME MARGARET "CRAFT",		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. 220-10-4882		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Cardiac arrest 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction, Inf., acute (c) A.S. & H. Cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 19 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Astute mellitus, med 1961 Post. lat. myocardial infarct 1961		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour "a.m." "p.m." 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7 Aug. 1966 to 27 Nov. 1967 , that (I) (we) last saw the deceased alive on 27 Nov. 1967 , and that death occurred at 9:45 P.M. from causes and on the date stated above			
22a. SIGNATURE W. A. Van Ormer		22b. DATE SIGNED 28 Nov. 67	
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF DEC 1, 1967	23c. NAME OF CEMETERY OR CREMATORY ZION MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) RFD3 CUMBERLAND ALLEGANY MD.
24. FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR STREET CUMBERLAND		25a. REC'D BY REGISTRAR DATE NOV 30 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

12788

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CHURCHMAN

GENERAL HOSPITAL

JAMES

NAME WHITE

W. W. ARINGTON

DR. W. D. VAN ORNER

CHURCHMAN, W.

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ARRINGTON

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GENERAL HOSPITAL, CUMBERLAND, MD.

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C. S. A.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14687

14698

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN Tb <u>Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>547 Greene St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Lester</u> Middle <u>Piper</u> Last <u>Beall</u>		4. DATE OF DEATH Month <u>November</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 9, 1904</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Technician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laboratory</u>	
11. BIRTHPLACE (State or foreign country) <u>Mount Savage, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph E. Beall</u>		14. MOTHER'S MAIDEN NAME <u>Ella M. Piper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-10-7803</u>	
17. INFORMANT <u>Mr. F. Carlton Beall</u>		Address <u>547 Greene St. Cumb. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO (b) <u>Cerebral infarction, left</u> DUE TO (c) <u>Cerebral thrombosis due to arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Shitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Shitarelic, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/29/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Allegany Md.</u>	
24. FUNERAL DIRECTOR <u>H. Wayne George Cumberland, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 30 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		22. DATE SIGNED <u>11/27/67</u>	

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
14688 Item #1d Film #G395 11/29/67 ph 14699										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD					
b. CITY OR TOWN (If outside corporate limits, write RURAL) CUMBERLAND			c. LENGTH OF STAY IN 1b 1MO 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN RURAL					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital					d. STREET ADDRESS RD#1 Londonderry Township			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First VELMA Middle I Last BINGMAN					4. DATE OF DEATH Month NOVEMBER Day 15 Year 19 67					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-11-1903		9. AGE (In years last birthday) yrs. 64		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) HYNDMAN, PA.			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN MADDEN					14. MOTHER'S MAIDEN NAME IDA E. WOLFORD					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) None				16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Ca of Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Art & Auto Cerebral									INTERVAL BETWEEN ONSET AND DEATH 6 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. City or town (County) (State) Cumberland, Md		
21. I certify that (I) (this hospital) attended the deceased from 4/16/67 , 19 to 11/15/67 , 19, that (I) (we) last saw the deceased alive on 11/14/67 , and that death occurred at 5:45 AM from causes and on the date stated above.										
22a. SIGNATURE DR. RICHARD J. WILLIAMS					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/15/67			
22c. PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS					22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Nov. 18, 1967		23c. NAME OF CEMETERY OR CREMATORY Palto Alto Cemetery			23d. LOCATION (City or Town) (County) (State) Hyndman, Pa. RD#1		
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa.					25a. REC'D BY REGISTRAR NOV 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14688

14700

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Frostburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		d. STREET ADDRESS 63 Grant Street	
3. NAME OF DECEASED (Type or print) Gilbert N. Bittner		4. DATE OF DEATH Month November Day 27 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-30-83
9. AGE (In years lost birthday) 84 yrs.		10. IF UNDER 27, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired; Celanese		10b. KIND OF BUSINESS OR INDUSTRY Celanese	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David Bittner		14. MOTHER'S MAIDEN NAME Ellen Shaffer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 216-10-6802	
17. INFORMANT P.O. Box 599, Cumberland, Md.		Allegany County Infirmary records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac arrest DUE TO (b) Chr. A.I.H.D. with mitral insufficiency DUE TO (c) Chr. obstructive pulmonary disease INTERVAL BETWEEN ONSET AND DEATH minutes many years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Dementia Arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/26 , 19 67 , to 11/27 , 19 67 , that (I) (we) last saw the deceased alive on 11/25 , 19 67 , and that death occurred at A. M. from causes and on the date stated above. at 10:23 A.M.			
22a. SIGNATURE John A. Topper		22b. DATE SIGNED Nov 27, 1967	
22c. PHYSICIAN'S NAME (Type) John A. Topper M.D.		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 11-30-1967	23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEMORIAL	23d. LOCATION (City or Town) (County) (State) FROSTBURG, ALLEG. MD.
24. FUNERAL DIRECTOR Joseph R. Dunst Sr. Hy. N.		25a. REC'D BY REGISTRAR DEC 5 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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FOR STATE
HEALTH DEPT

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VR A15M 19
6M 1/66

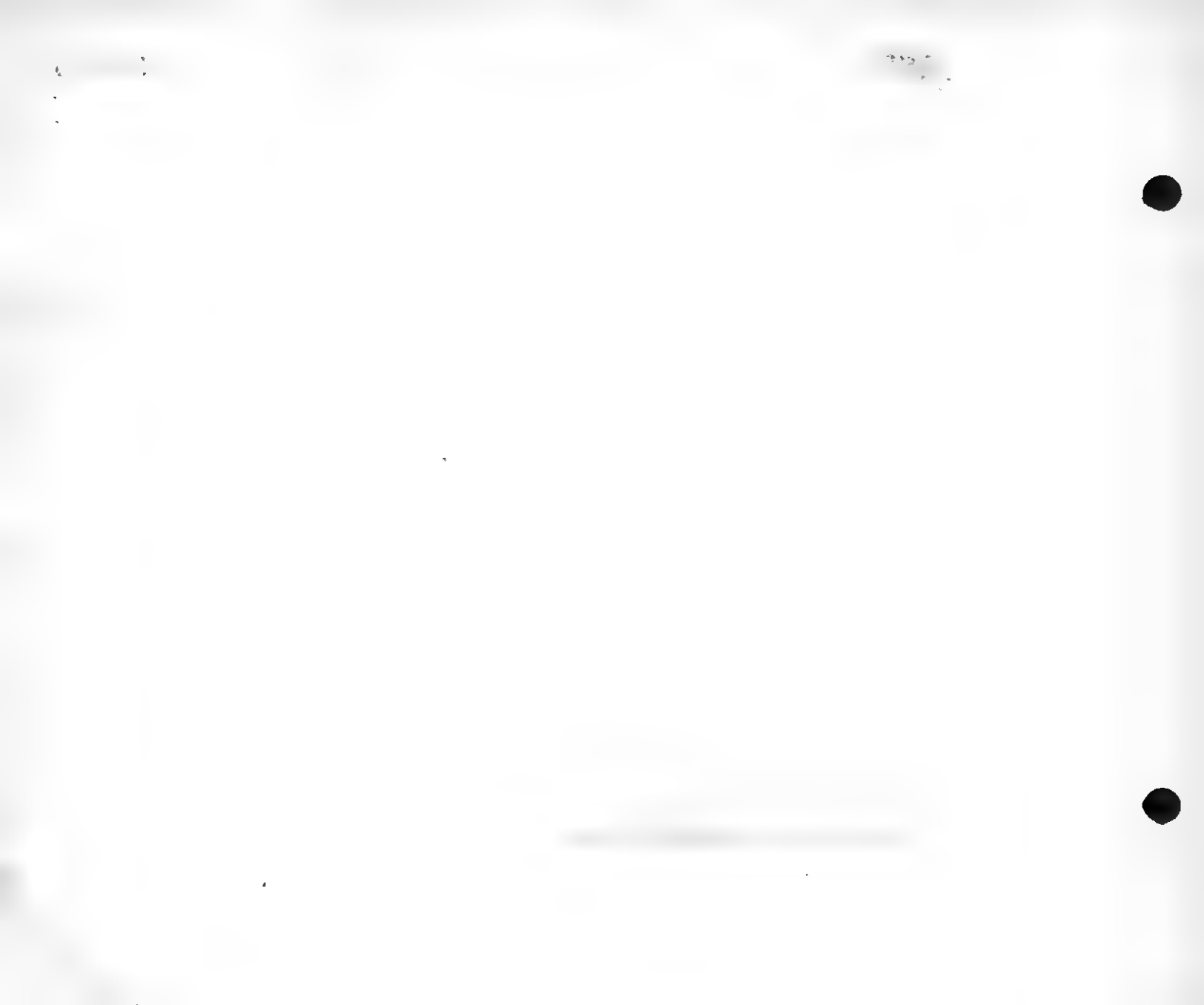
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14690

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14701

1 PLACE OF DEATH a COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c LENGTH OF STAY IN 1b 1. MONTH	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e STREET ADDRESS 817 MEMORIAL AVE.	
3 NAME OF DECEASED (Type or print) First OWEN Middle J. Last BRADY		4 DATE OF DEATH Month NOV. Day 13 Year 19 67	
5 SEX MALE	6 CD. DR. OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH APRIL 4, 1895
9 AGE (In years last birthday) 72 yrs		10 IF UNDER 1 YEAR Months 13 Days 19 Hours 67 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPER INTENDENT		10b KIND OF BUSINESS OR INDUSTRY CELANESE CORP.	
11 BIRTHPLACE (State or foreign country) W. VA.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME OWEN J. BRADY		14. MOTHER'S MAIDEN NAME ANNA M. HINES	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214 07 5892-A	
17 INFORMANT WILLIAM P. BRADY		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 4 x 11 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Coronary Sclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH SHORT ---
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARRELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 13, 1967 Address (Street, city, town, or county) Cumberland, Maryland	
23a BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b DATE THEREOF NOV. 16, 1967	23c NAME OF CEMETERY OR CREMATORY ST. PETER & PAUL CEM.	23d LOCATION (City or Town) (County) (State) CUMBERLAND, MD.
24 FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.	
25a. REC'D BY REGISTRAR NOV 16 1967		25b REGISTRAR'S SIGNATURE John Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND

14691

CERTIFICATE OF DEATH

14702

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Midland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dans Rock Road		d. STREET ADDRESS Dans Rock Road	
3. NAME OF DECEASED (Type or print) First Ruth Middle E. Last Brinegar		4. DATE OF DEATH Month Nov Day 9 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/22/1898
9. AGE (in years last birthday) yrs 69		10. FUNDING YEAR Months 1 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Parkersburg, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hugh Brinegar		14. MOTHER'S MAIDEN NAME Clarinda Knight	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Walter Brinegar		Address Midland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage - DUE TO Severe arteriosclerotic CVD - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) years (c)		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 65 to Nov. 9 , 19 67 that (I) (we) last saw the deceased alive on Nov 7 , 19 67 , and that death occurred at 8 A.M. from causes and on the date stated above.			
22a. SIGNATURE John B. Davis , M.D.		22b. DATE SIGNED 11/10/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/12/1967	
23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City or Town) (County) (State) Frostburg A. Md.	
24. FUNERAL DIRECTOR George Eichhorn		25a. REC'D BY REGISTRAR Lonaconing, Md.	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		25c. DATE NOV 13 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14692

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14783

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First PETER Middle A. Last BRINER			4. DATE OF DEATH Month 11/26/1967 Day 19 Year 19		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/31/1894	9. AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR Months 11 Days 26 Hours 19 Min 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police Officer-Town of Midland		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Eckhart, Md.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Peter Briner		
14. MOTHER'S MAIDEN NAME Margdalene Ellinger			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes-World War # 1		
16. SOCIAL SECURITY NO.			17. INFORMANT Address Miss Grace Briner, Midland, Md.		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary Occlusion (Daughter) INTERVAL BETWEEN CAUSE AND DEATH Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: DUE TO (b) Coronary Sclerosis DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelis M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 11/26/1967		22. DATE SIGNED	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/29/1967	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION (City or town)	(County)	(State)
24. FUNERAL DIRECTOR George Eichhorn			25a. REC'D BY REGISTRAR Lonaconing, Md.		
25b. REGISTRAR'S SIGNATURE Charles Judge			DATE NOV 28 1967		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

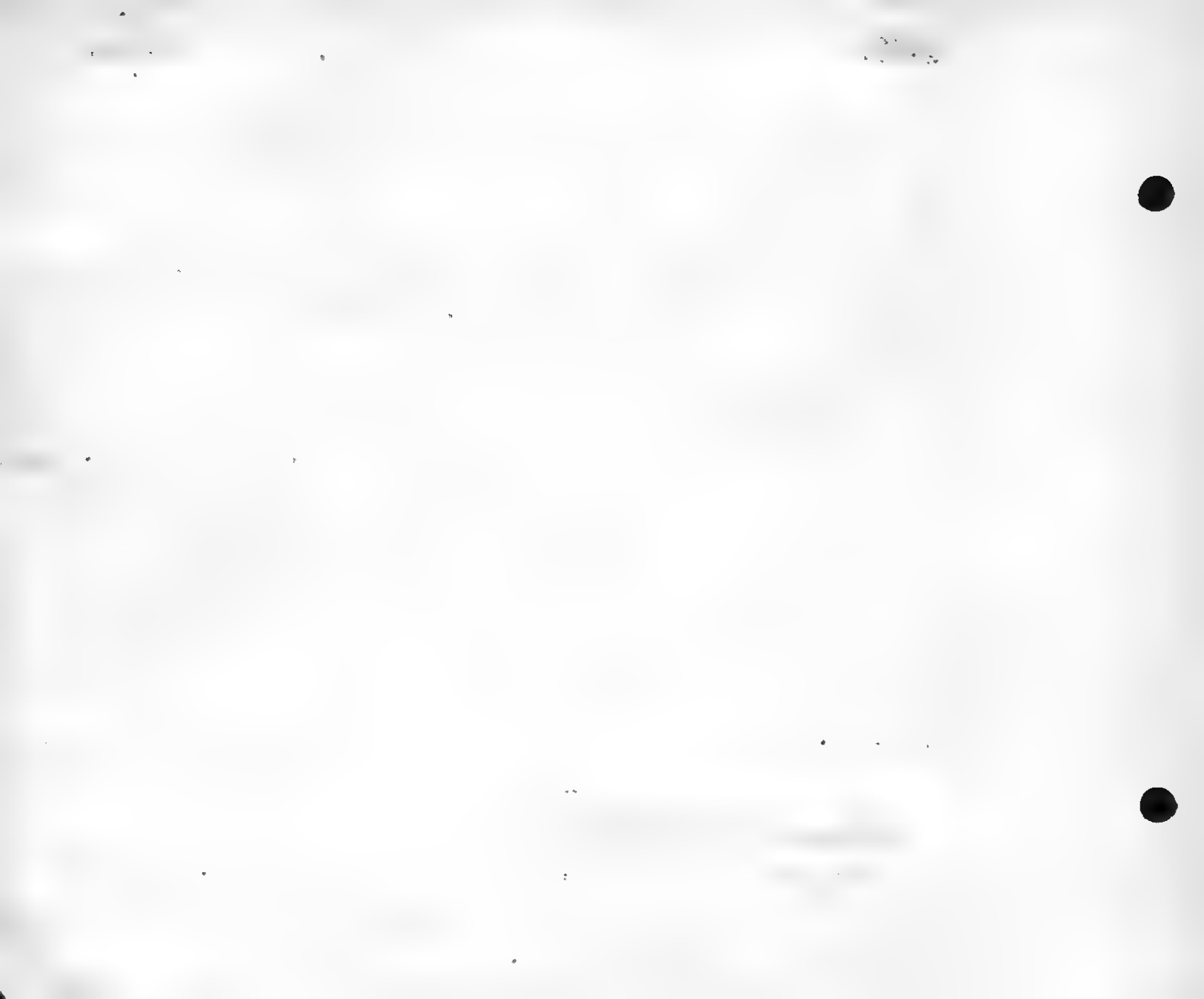
FOR STATE
HEALTH DEPT.

14693

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14704

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN TOWN 81 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. STREET ADDRESS 501 Oldtown Road	
3 NAME OF DECEASED (Type or print) First Middle Last Miss Elizabeth Catherine Brinker		4 DATE OF DEATH Month Day Year Nov. 3 19 67	
5. SEX Female (F)	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17, 1886
9. AGE (in years last birthday) yrs 81		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		12. KIND OF BUSINESS OR INDUSTRY Own Home	
13. BIRTHPLACE (State or foreign country) Cumberland, Md.		14. C. T. ZEN OF WHAT COUNTRY? USA	
15. FATHER'S NAME Mathias Brinker		16. MOTHER'S MAIDEN NAME Louise Ruppenkamp	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		18. SOCIAL SECURITY NO no	
19. INFORMANT Mrs. Dorothy Roby, Cumberland, Md. Niece		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Right Tibia & Fibula DUE TO (b) (Pathologic) Carcinoma of Breast With Metastasis DUE TO (c) 25 Years		INTERVAL BETWEEN ONSET AND DEATH 29 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Fell at Home	
20c. TIME OF INJURY Month Day Year Hour 10:00 Nov. 3 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cumberland, Allegany, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Nov. 3, 1967	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED	
Address (Street, city, town, or county) Rt. 9 Cumberland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 6, 1967	23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE NOV 8 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14694

14705

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 223 OFFUTT STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First CALBERT Middle BUSSARD Last BUSSARD				4 DATE OF DEATH Month NOVEMBER Day 1 Year 67			
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-19-02		9 AGE (In years lost day) 65 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist Helper			10b. KIND OF BUSINESS OR INDUSTRY Railroad		11 BIRTHPLACE (County & State, or foreign country) BEDFORD, PA.		
12 CITIZEN OF WHAT COUNTRY U.S.A.				13. FATHER'S NAME BUSSARD, (Harold)			
14 MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. 705-07-9643		17 INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Coronary Sclerosis DUE TO (c) 134							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumbrldg, Md				
21. I certify that (I) (this hospital) attended the deceased from 11/3/67 , 19 67 , that (I) (we) last saw the deceased alive on 11/1/67 , 19 67 , and that death occurred at 9:05 P.M. , from causes and on the date stated above.							
22a. SIGNATURE DR. R. J. WILLIAMS			22b. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22c. ADDRESS CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 4, 1967		23c. NAME OF CEMETERY OR CREMATORY Fellowship Cemetery		23d. LOCATION (City or Town) (County) (State) Centerville, Pa.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.			25a. REC'D BY REGISTRAR NOV 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

RE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14695

Item #24 Film #1275 12/20/67

CERTIFICATE OF DEATH

14706

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 24 HOURS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HOLMES H. CESSNA		4. DATE OF DEATH Month NOV. Day 21 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-24-01
9. AGE (In years lost birthday) 66 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COIN SHOP OWNER	11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND (ALLEGANY) MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN C. CESSNA	
14. MOTHER'S MAIDEN NAME JANE (HOUCK)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO 214-05-4006		17. INFORMANT HOSPITAL RECORD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH CAUSED BY: 4222 IMMEDIATE CAUSE (a) pulmonary edema DUE TO (b) congestive heart failure DUE TO (c) chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 1 day 1 month 6 months
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic alcoholism, since malnutrition			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-3-1967 , to 11-21-1967 , that (I) (we) last saw the deceased alive on 11-21-1967 , and that death occurred at 11-21-1967 M, from causes and on the date stated above			
22a. SIGNATURE L. Lewis Brings		22b. DATE SIGNED 11-22-67	
22c. PHYSICIAN'S NAME (Type) DR. LEWIS BRINGS		22d. ADDRESS 57 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/24/67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.	23d. LOCATION (City or town) (County) (State) Cumberland, MD.
24. FUNERAL DIRECTOR STEIN'S FUNERAL HOME		25a. REC'D BY REGISTRAR Nov 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14696

CERTIFICATE OF DEATH

14707

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	c LENGTH OF STAY IN TB 10 DAYS 6HRS	c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) CUMBERLAND	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d STREET ADDRESS APT 408 KENNEDY APTS MECHANIC STREET IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last MILO H CLEM SR.		4 DATE OF DEATH Month Day Year NOVEMBER 1, 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-1886
9. AGE (In years last birthday) 81		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Yard Foreman		10b KIND OF BUSINESS OR INDUSTRY Railroad	11 BIRTHPLACE (County & State or foreign country) W. VIRGINIA Alta Terre
12 C TIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME JAMES CLEM	
14. MOTHER'S MAIDEN NAME ISABELLE WILES		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Post operative-Intestinal Obstruction DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Age-Arteriosclerosis-Generalized:			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1960 , 19 to Nov 1, 1967 , that (I) (we) last saw the deceased alive on Oct. 21, 1967 , and that death occurred at 6:00AM from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 11-1-67	
22c. PHYSICIAN'S NAME (Type) DR. G. OVERTON HIMMELWRIGHT		22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 3, 1967	23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery	23d. LOCATION (City or town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE NOV 8 1967	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14697

CERTIFICATE OF DEATH

14708

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) FROSTBURG	
c. LENGTH OF STAY IN 1b LIFETIME		d. STREET ADDRESS 115 SPRING STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DEANNA Middle WILLIAMS Last COLE		4. DATE OF DEATH Month NOVEMBER Day 11 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE NEGROE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 6, 1898
9. AGE (In years last birthday) 69		10. UNDER 1 YEAR Months 11 Days 11 Hours 11 Min 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH WILLIAMS		14. MOTHER'S MAIDEN NAME JENNIE EDLONDSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NC N.A.		16. SOCIAL SECURITY NO. 215-18-8165-B	
17. INFORMANT MR. ERNEST A. COLE, JR.		18. ADDRESS STREET, FROSTBURG, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage. DUE TO (b) Generalized atherosclerosis DUE TO (c) Essential hypertension.		INTERVAL BETWEEN ONSET AND DEATH 12 hr. 15 yr 30 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obesity, ect.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from November 11, 1967 to Nov. 11, 1967 , that (I) (we) saw the deceased alive on Nov. 11, 1967 , and that death occurred at 2:50 PM , from causes and on the date stated above			
22a. SIGNATURE Alvin J. Walters		22b. DATE SIGNED 11/14/67	
22c. PHYSICIAN'S NAME (Type) ALVIN J. WALTERS, M.D.		22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 14, 1967	
23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK		23d. LOCATION (City or town) (County) (State) FROSTBURG MARYLAND	
24. FUNERAL DIRECTOR ARLLOU M. SOWERS, HAFFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG, MD.		25a. REC'D BY REGISTRAR NOV 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14698

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14709

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 50 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Memorial Hospital		d. STREET ADDRESS 311 S. Cedar St.	
3. NAME OF DECEASED (Type or print) First Pete Middle Conis Last Conis		4. DATE OF DEATH Month Nov. Day 11 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1896
9. AGE (In years last birthday) yrs 71		10. IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min. 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Calabria, Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Conis		14. MOTHER'S MAIDEN NAME Grace Gallizzi	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Mary Conis, Cumberland, Md. Wife		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) --- (c) ---		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Benedict Skitarelic M.D.		ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or town) (County) (State) Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR NOV 14 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		22. DATE SIGNED Nov. 11, 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14710			
14699											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL						d. STREET ADDRESS 2 A FT. CUMBERLAND HOMES					
3. NAME OF DECEASED (Type or print) First LEWIS Middle R. Last CRABTREE						4. DATE OF DEATH Month NOVEMBER Day 6 Year 67					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-6-1889		9. AGE (In years lost birthday) 78 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orderly				10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (County & State, or foreign country) OLDTOWN, MD.				12. CITIZEN OF WHAT COUNTRY S. A.	
13. FATHER'S NAME LEONARD S. CRABTREE						14. MOTHER'S MAIDEN NAME FANNIE MYERS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE										INTERVAL BETWEEN ONSET AND DEATH 7?	
DUE TO ARTERIOSCLEROTIC HEART DISEASE											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO (b)											
DUE TO (c)											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11 6 , 19 67 at 8:35 P.M. , 19 67 that (I) (we) last saw the deceased alive on 11-6 , 19 67 and that death occurred at 8:35 P.M. , 19 67 from causes and on the date stated above											
22a. SIGNATURE <i>Thomas Lusby</i>						22b. DATE SIGNED 11/6/67					
22c. PHYSICIAN'S NAME (Type) DR. THOMAS LUSBY						22d. ADDRESS CAVALE, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Nov. 9, 1967		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park			23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR NOV 10 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



CERTIFICATE OF DEATH

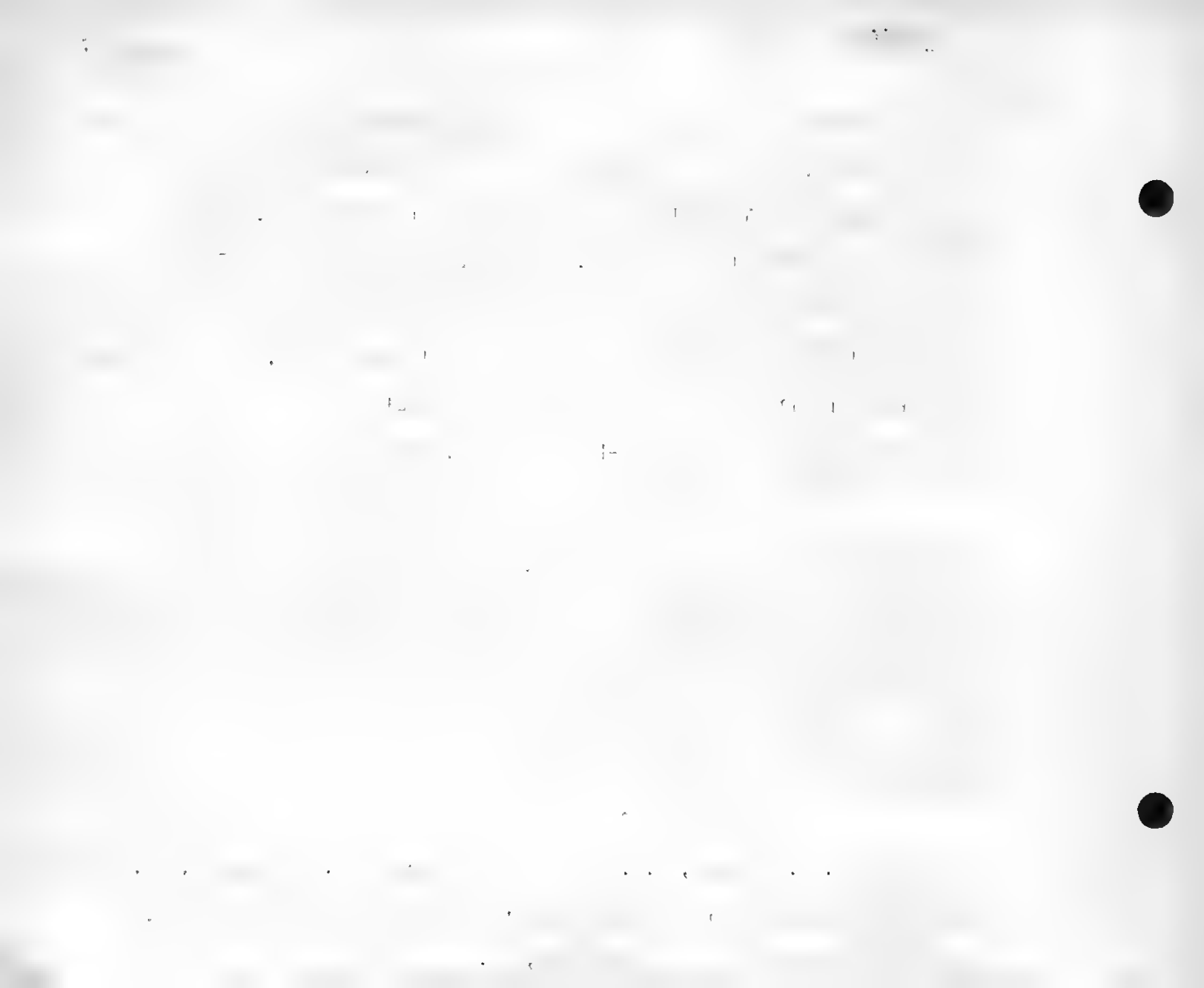
14711

14700

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 23 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LORRAINE Middle A. Last CULLEN		4. DATE OF DEATH Month NOVEMBER Day 26 Year 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-25-27
9. AGE (In years last birthday) 40 yrs		F. UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) KITZMILLER, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PETER PRATT		14. MOTHER'S MAIDEN NAME SICOLI	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 212-24-1825	
17. INFORMANT HOSP. RECORD		Address	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DIABETIC NEPHROSCLEROSIS DUE TO (c) DIABETES		INTERVAL BETWEEN ONSET AND DEATH (3) MONTHS 4 YEARS 17 YRS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HYPERTENSIVE HEART DISEASE & HEART FAILURE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/25 , 19 67 to 11/26 , 19 67 ; that (I) (we) saw the deceased alive on 11/25 , 19 67 , and that death occurred at 11:30 M, from causes and on the date stated above.			
22a. SIGNATURE S. G. WEISMAN		22b. DATE SIGNED 11/26/67	
22c. PHYSICIAN'S NAME (Type) S. G. WEISMAN, M.D.		22d. ADDRESS 59 GREENE ST. CUMBERLAND, MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 29 '67	
23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR DURST FUNERAL HOME		25a. REC'D BY REGISTRAR DEC 1 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14701

CERTIFICATE OF DEATH

14712

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN lb <u>66 Yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>825 Braddock Road, Cumberland, Md.</u>		d. STREET ADDRESS <u>825 Braddock Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rebecca Jeannette Dantzic</u>		4. DATE OF DEATH Month Day Year <u>11-5-1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>musician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pianoist</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Cumberland Allegany, Md.</u>
13. FATHER'S NAME <u>Jacob Dantzic</u>		14. MOTHER'S MAIDEN NAME <u>Celia (Batnick)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>220-16-5955</u>	17. INFORMANT <u>Dr. Ethyl Dantzic</u>
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Colon with</u> <u>metastasis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastasis.</u> (c) <u>metastasis.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-4-63</u> , 19 <u>63</u> to <u>11-5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-3</u> , 19 <u>67</u> , and that death occurred at <u>745</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Clarence J. Vincent</u>		22b. DATE SIGNED <u>11-6-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Clarence J. Vincent</u>		22d. ADDRESS <u>124 N. Smallwood St., Cumb., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-8-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>East View Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Cumberland Allegany, Md.</u>
24. FUNERAL DIRECTOR ADDRESS <u>H. Lee Silcox 404 Decatur St., Cumb., Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 9 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME15
6M 1/67

14713

14702

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Allegany	
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Cumberland		c LENGTH OF STAY IN TB 50 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O.A. Memorial Hospital		d STREET ADDRESS 219 Emily Street	
3 NAME OF DECEASED (Type or print) First Thomas Middle Arner Last Dentinger		4 DATE OF DEATH Month Nov. Day 10 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 16, 1909
9 AGE (In years last birthday) yrs 58		10 IF UNDER 1 YEAR F UNDER 24 HRS Months Ooys Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C. A. Dept.		10b. KIND OF BUSINESS OR INDUSTRY Textile Ind.	
11. BIRTHPLACE (State or foreign country) Weissport, Pa.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William Dentinger		14 MOTHER'S MAIDEN NAME Hazel Green	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 214-07-5150	
17 INFORMANT Mrs. Lillie Dentinger, Cumberland, Md.		Address Wife	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) --- (c) ---		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Nov. 10, 1967	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county) Rt. 9 Cumberland		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 12, 1967	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.
24 FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR NOV 14 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	

14703

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 122 S. MECHANIC ST.	
3 NAME OF DECEASED (Type or print) FRANCIS A. DICK		4. DATE OF DEATH Month NOVEMBER Day 11 Year 1967	
5 SEX MALE	6. COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1898 11-26-1898 (68 yrs)
9 AGE (In years last b. day) 68 yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11 BIRTHPLACE (County & State, or foreign country) SOMERSET CO. PA.		12 CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Christian Dick		14 MOTHER'S MAIDEN NAME Elizabeth Hedrick	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 705-05-4452	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1965 , 198:5 to 8/11/67 , that (I) (we) lost saw the deceased alive on 11-11-1967 , and that death occurred at 11 M, from causes and on the date stated above			
22a. SIGNATURE William P. James M.D.		22b. DATE SIGNED 4/14/67	
22c. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 14, 1967	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	23d. LOCATION (City or town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE NOV 16 1967	25b. REGISTRAR'S SIGNATURE William J. Judge



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME15
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14704

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14715

1 PLACE OF DEATH a COUNTY <u>Allegheny</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Allegheny</u>	
b CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c LENGTH OF STAY IN TB	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hosp.</u>		e STREET ADDRESS <u>Along U. S. Rt. # 220</u>	
3 NAME OF DECEASED (Type or print) First <u>Melvin</u> Middle <u>Leroy</u> Last <u>Dixon</u>		4 DATE OF DEATH Month <u>November</u> Day <u>13</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 30, 1966</u>
9 AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months <u>10</u> Days <u>14</u> Hours <u>19</u> Min <u>67</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None (infant)</u>		10b KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11 BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>Melvin L. Dixon, Sr.</u>		14 MOTHER'S M maiden name <u>Theresa Grogg</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>None</u>	
17 INFORMANT <u>Mr. Melvin L. Dixon, Sr.</u>		Address <u>Rawlings, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>7543</u> <u>Acute Cardiac Failure; Hydrothorax;</u> Hours <u>---</u>			
DUE TO (b) <u>Congenital Anomalies of Heart</u> <u>---</u>			
DUE TO (c) <u>(Patent foramen ovale; Patent ductus arteriosus; Aortic Stenosis)</u> <u>---</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitaralic</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitaralic, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Rt. # <u>9</u>	
Address (Street, city, town, or county) <u>Cumberland, Md.</u>		11/13/67 22. DATE SIGNED	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>11/16/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Waxler Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Dawson, Allegheny Maryland</u>	
24 FUNERAL DIRECTOR <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Maryland</u>	
25a REC'D BY REGISTRAR <u>NOV 17 1967</u>		25b REGISTRAR'S SIGNATURE <u>William J. Yager</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
25M 1/67

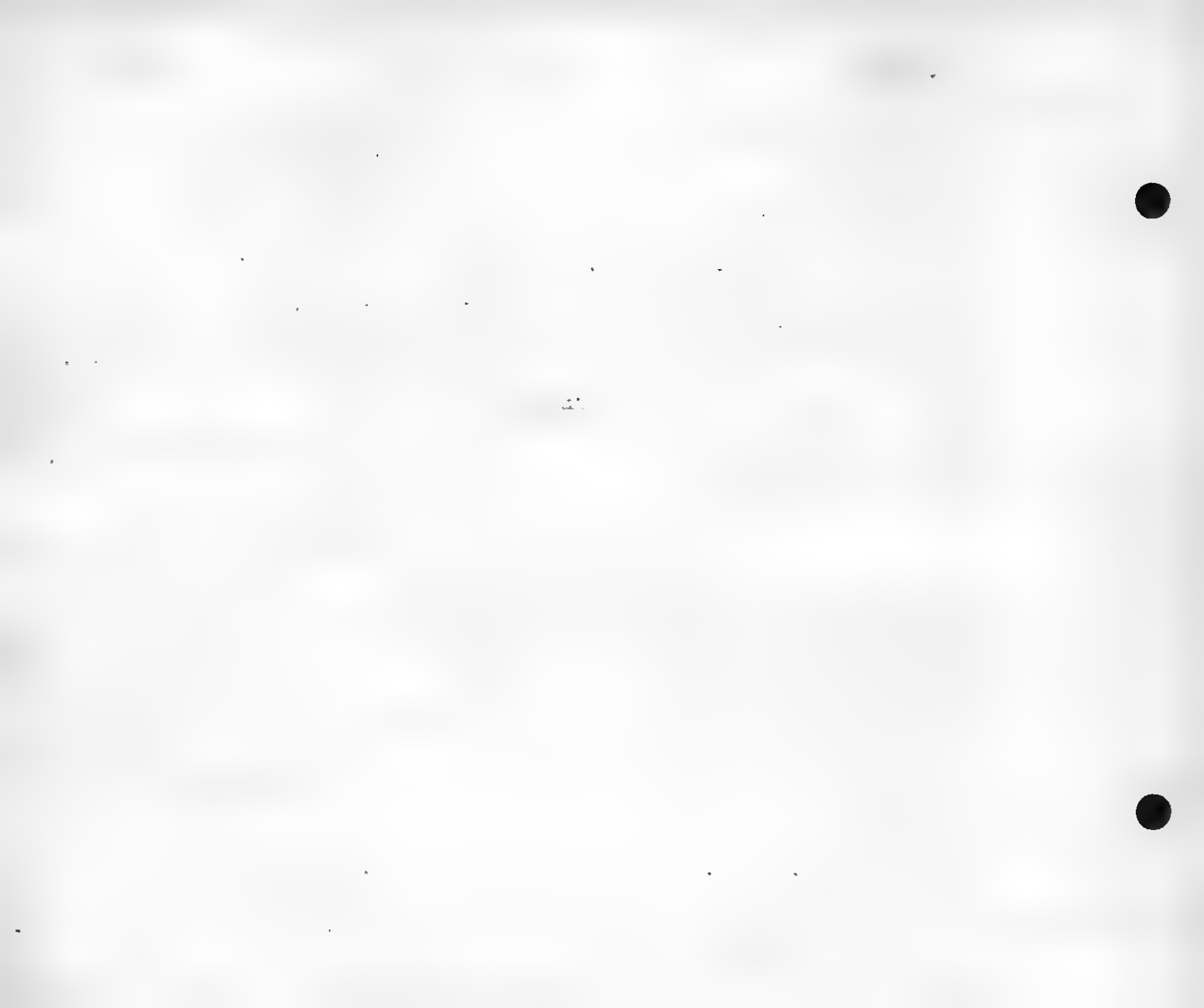
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14705

CERTIFICATE OF DEATH

14716

1. PLACE OF DEATH a COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits, give nearest town) CUMBERLAND		c LENGTH OF STAY IN b 2 DAYS	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FLINTSTONE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS ROUTE #2,	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First VERNELDA Middle G. Last DONAHOE		4. DATE OF DEATH Month NOV. Day 19, Year 67.	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-10-1912
9. AGE (In years last birthday) yrs 55		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (County & State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME ALFRED BENNETT		14. MOTHER'S MAIDEN NAME MARY TWIGG	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) metastatic Ca - lung, skin, bone Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) Adenoc Ca of left breast DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 7 yr 2-3 yr	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1965 to Nov 19 1967 , that (I) (we) last saw the deceased alive on Nov 19 1967 , and that death occurred on Nov 19 1967 at 10:00 A.M. , from causes on and on the date stated above			
22a. SIGNATURE Dr. A. J. Mirkin		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. A. J. MIRKIN		22d. ADDRESS 115 S. CENTRE ST. CUMBERLAND, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 22 1967	
23c. NAME OF CEMETERY OR CREMATORY SEVEN DOLOES CATHOLIC CEMT.		23d. LOCATION (City or Town) (County) (State) BEANS COVE, BEDFORD PA.	
24. FUNERAL DIRECTOR H: LEE SILCOX 404 DECATUR STREET CUMBERLAND, MD		25a. REC'D BY REGISTRAR DATE NOV 22 1967	
		25b. REGISTRAR'S SIGNATURE John J. Judge	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14708

CERTIFICATE OF DEATH

14717

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 20 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS RT 4 BOX 299	
3. NAME OF DECEASED (Type or print) First MARIE Middle MIDDLETON Last DUVALL		4. DATE OF DEATH Month NOVEMBER Day 27 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-22-01
9. AGE (In years lost birthday) 66 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS MIDDLETON		14. MOTHER'S MAIDEN NAME LAURA TWIGG	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-46-1956	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic lymphatic Leukemia 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/27/67 , 19 67 , that (I) (we) last saw the deceased alive on 11/27 19 67 , and that death occurred at 6:40 P.M. M, from causes and on the date stated above.			
22a. SIGNATURE Dr. I. Dross		22b. DATE SIGNED 11/28/67	
22c. PHYSICIAN'S NAME (Type) DR. I. DROSS		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/30/1967	
23c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Methodist Cem		23d. LOCATION (City or Town) (County) (State) Allegany County Md.	
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REGISTRAR DEC 4 1967	
25b. REGISTRAR'S SIGNATURE John J. Hafer, Jr.		25c. REGISTRAR'S SIGNATURE John J. Hafer, Jr.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14707						14718					
1 PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)					
a. COUNTY			ALLEGANY			a STATE			MARYLAND		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			FROSTBURG			b COUNTY			ALLEGANY		
c LENGTH OF STAY IN			LIFE			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			FROSTBURG		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d STREET ADDRESS			e IS RESIDENCE ON A FARM?		
256 E. MAIN STREET						256 E. MAIN STREET			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print)						4 DATE OF DEATH					
F. MELVIN EICHHORN						NOVEMBER 10, 19 67					
5. SEX		6 COLOR OR RACE		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8 DATE OF BIRTH		9 AGE (In years last birthday) yrs		IF UNDER 1 YEAR	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		JULY 12, 1894		73		Months Days Hours Mn.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country)			12 CITIZEN OF WHAT COUNTRY?		
RETIRED SALESMAN				PBGR. PLATE GLASS		MARYLAND			U.S.A.		
13. FATHER'S NAME						14 MOTHER'S MAIDEN NAME					
FREDERICK R. EICHHORN						SOPHIA REIDLER					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16 SOCIAL SECURITY NO		17 INFORMANT Address					
YES				W-1		220-10-7466		MRS. ELIZABETH EICHORN, FROSTBURG, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)										years	
DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										years.	
(b)											
DUE TO											
(c)											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year				20d INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town)		(County) (State)	
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21 I certify that (I) (this hospital) attended the deceased from Jan 1967 to Nov 10, 1967 that (I) (we) last saw the deceased alive on Nov 9 1967 and that death occurred at 4 P.M. from causes and on the date stated above											
22a SIGNATURE						ATTENDING PHYS		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED	
John B. Davis, M.D.						<input checked="" type="checkbox"/>				11/10/67	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
JOHN B. DAVIS, M. D.						2 BROADWAY, FROSTBURG, MD.					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
BURIAL			11-13-67		ST. MARY'S CEMETERY			CUMBERLAND, MD.			
24 FUNERAL DIRECTOR ADDRESS						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
JOSEPH R. DURST, SR., FROSTBURG, MD. 21532						DATE NOV 14 1967		J. H. H. Judge			



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15MEWJ
6M 1/67

14708

Item 9 Film 6295 11/21/67 sk

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14719

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY in lb 8 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miner's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas J Eisentrou		4. DATE OF DEATH November 12 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-31-82
9. AGE (In years last birthday) 86 85 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Mines	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Eisentrou		14. MOTHER'S MAIDEN NAME Mary Ann Fee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-01-3649-A	
17. INFORMANT Miner's Hospital, Frostburg, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism, Massive DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Comminuted Fracture Left Radius DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell at home in his yard	
20c. TIME OF INJURY Month, Day, Year - 3:00 p.m. Nov. 3 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Yard at Home		20f. (City or town) (County) (State) Frostburg, Allegany, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		22. DATE SIGNED November 12, 1967	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		Address (Street, city, town, or county) RD 9, Cumberland, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 15 '67	
23c. NAME OF CEMETERY OR CREMATORY Fbg. Memorial Park		23d. LOCATION (City or town) (County) (State) Frostburg, Md. 21532	
24. FUNERAL DIRECTOR Joseph R. Durst, Sr., Frostburg, Md. 21532		25a. REC'D BY REGISTRAR NOV 17 1967	
25b. REGISTRAR'S SIGNATURE James Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 67

FOR STATE
HEALTH DEPT.

1

14720

14708

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived) 1 instant on Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD 2 CUMBERLAND MARYLAND		c LENGTH OF STAY IN IL 59 YRS	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD 2 CUMBERLAND, MD.		d STREET ADDRESS RFD 2 CUMBERLAND, MD.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD 2 CUMBERLAND, MD.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) MARTON MONROE FEY		4 DATE OF DEATH Month NOV Day 12 Year 19 67	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH FEB. 23, 1908
9 AGE (In years last birthday) yrs 59		IF UNDER 1 YEAR Months 12 Days 19 Hours 67 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOTEL OWNER		10b KIND OF BUSINESS OR INDUSTRY MOTEL	
11 BIRTHPLACE (State or foreign country) CRESAPTOWN, MARYLAND		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Gibson JAMES KKKKK STARKEY		14 MOTHER'S MAIDEN NAME BERTHA (McBEE) STARKEY	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16 SOCIAL SECURITY NO 214-05-7711	
17 INFORMANT MR. GEORGE C. FEY SR.		Address BALTIMORE PIKE RFD 2 CUMBERLAND, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Coronary Sclerosis DUE TO (c) Sudden		INTERVAL BETWEEN ONSET AND DEATH ---	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) ---		19 WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> at work hot While <input type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED November 12, 1967	
ACTUAL SIGNATURE Benedict Skitarelic EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) Cumberland, Maryland	
23c BURIAL CREMATION REMOVAL (Specify) BURIAL		23b DATE THEREOF 14 NOV 67	
23c NAME OF CEMETERY OR CREMATORY ROSEHILL CEMETERY		23d LOCATION (City or town) (County) (State) CUMBERLAND ALLEGANY MD.	
24 FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR STREET CUMBERLAND		25a REC'D BY REGISTRAR NOV 14 1967	
25b REGISTRAR SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

362

14710

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14721

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN TB LIFE	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		d. STREET ADDRESS 70 S. WATER STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) CLIFTON GEIS		4. DATE OF DEATH Month NOVEMBER Day 26 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 14, 1883
9 AGE (In years last birthday) yrs 84		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED	
11 BIRTHPLACE (County & State, or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN GEIS		14. MOTHER'S MAIDEN NAME JULIA LAPP	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 213-22-3099	
17 INFORMANT MRS. MILDRED COAKLEY, FROSTBURG, MD.		Address 14 W. MAIN ST.,	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Atherosclerosis - generalized DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 20, 1967 , to Nov. 26, 1967 , that (I) (we) last saw the deceased alive on Nov. 26, 1967 , and that death occurred at 10:30 PM , from causes and on the date stated above.			
22a SIGNATURE L.R. Miles, Jr.		22b. DATE SIGNED 11-28-67	
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.		22d. ADDRESS WONACONING MD 21539	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF NOV. 29 '67	
23c NAME OF CEMETERY OR CREMATORY FBG. MEMORIAL PARK		23d LOCATION (City or Town) (County) (State) FROSTBURG, MD.	
24 FUNERAL DIRECTOR JOSEPH F. DURST, SR., FROSTBURG, MD. 21532		25a. REC'D BY REGISTRAR DEC 1 1967	
25b. REGISTRAR'S SIGNATURE L.R. Miles, Jr.			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14722

14711

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b DOA MEMORIAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA MEMORIAL HOSPITAL			d. STREET ADDRESS 22 MARION STREET		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First ROBERTA Middle VIRGINIA Last GOLDEN			4 DATE OF DEATH Month NOV. Day 22 Year 19 67		
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH FEB. 22, 1895		9 AGE (In years last birthday) yrs 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11 BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND	
12 CITIZEN OF WHAT COUNTRY? USA					
13 FATHER'S NAME ROBERT C. STOTLER			14 MOTHER'S MAIDEN NAME VIRGINIA "DRAKE" STOTLER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17 INFORMANT MR. D. HUGO GOLDEN 22 MARION ST. CUMBERLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 4301 IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH SUDDEN					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____					
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic EXAMINER'S NAME (Type)		BENEDICT SKITARELIC, M.D.		22. DATE SIGNED November 22, 1967 Address (Street, city, town or county) Cumberland, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 25 NOV 67		23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK	
23d. LOCATION (City or town) _____ (County) _____ (State) _____ CUMBERLAND ALLEGANY MARYLAND					
24 FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR ST., CUMBERLAND MD.		25a. RECEIVED BY REGISTRAR NOV 27 1967		25b. REGISTRAR'S SIGNATURE James Judge	

14712

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 404½ N. CENTRE STREET	
3 NAME OF DECEASED (Type or print) LUCY First Middle H. Last GOVER		4 DATE OF DEATH Month 11 Day 24 Year 19 67	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 06-07-94
9 AGE (In years lost birthday) yrs 73		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALESLADY		10b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE	11. BIRTHPLACE (County & State or foreign country) WALES, GREAT BRITAIN
12 CITIZEN OF WHAT COUNTRY? ENGLAND		13 FATHER'S NAME ISAAC HALE	
14. MOTHER'S MAIDEN NAME GRACE (BAILY)		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16 SOCIAL SECURITY NO 219-03-9979		17 INFORMANT HOSPITAL RECORD	
Address 900 SETON DRIVE., CUMB		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Myeloma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept., 1965, to Nov., 1967, that (I) (we) last saw the deceased alive on 11-03 1967, and that death occurred at 9:30 A.M. from causes and on the date stated above			
22a. SIGNATURE Wayne C Spiegel + M. Glick M.D.		22b. DATE SIGNED 11/24/67	
22c. PHYSICIAN'S NAME (Type) DR. M. GLICK		22d. ADDRESS 126 N. SMALLWOOD STREET	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov. 26-1967	
23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.	
24 FUNERAL DIRECTOR DURST FUNERAL HOME-57 FROST AVE., FROST., MD.		25a. REC'D BY REGISTRAR DATE NOV 28 1967	
25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

14713

14724

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 8/26/1966	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. STREET ADDRESS 77 Douglas Avenue	
3. NAME OF DECEASED (Type or print) Jessie T. Greene		4. DATE OF DEATH Month November Day 8 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/9/1873
9. AGE (In years last birthday) 94 yrs		IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS: Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Louisville, Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Trezise		14. MOTHER'S MAIDEN NAME Martha Eden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT P.O. Box 599, Cumberland, Md.		Allegany County Infirmary records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Acute Myocardial Infarction DUE TO Chl. A.S.C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) many years DUE TO Generalized Arteriosclerosis (c) many years			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Heart Syndrome Diabetes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	
20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/26/1966 to 11/8/1967 , that (I) (we) last saw the deceased alive 11/8/1967 , and that death occurred at A. M. from causes and on the date stated above			
22a. SIGNATURE John A. Topper M.D.		22b. DATE SIGNED 11/8/1967	
22c. PHYSICIAN'S NAME (Type) John A. Topper		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/11/1967	
23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Lonaconing, Md.	
24. FUNERAL DIRECTOR George Eichhorn, Lonaconing, Md.		25a. REC'D BY REGISTRAR NOV 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14714

14725

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrettsburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Star Rt., Garrettsburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Secord Heart Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Benedict Skitaralic</u>		4. DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. CO. OR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 11, 1967</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. <u>11</u> IF UNDER 1 YEAR Months <u>1</u> Days <u>3</u> IF UNDER 24 HRS Hours <u>11</u> M.n. <u>2</u>
11. BIRTHPLACE (State or foreign country) <u>Bosnia, Yugoslavia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yugoslavia</u>	
13. FATHER'S NAME <u>Bernard Gutaric</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Garlick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Benedict Skitaralic</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY <u>1542</u> IMMEDIATE CAUSE (a) <u>Acute myocardial infarction, Large</u> DUE TO (b) <u>Coronary artery disease</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Edema, Hydrothorax, Pericardial Effusion</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 1 of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>11</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitaralic</u> M.D.		22. DATE SIGNED <u>November 12, 1967</u>	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARALIC, M.D.</u>		Address (Street, city, town, or county) <u>Garrettsburg, Maryland</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/14/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Ann's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Garrettsburg, Garrett Co., Md.</u>
24. FUNERAL DIRECTOR <u>Ruth Newman</u>		25a. REC'D BY REGISTRAR <u>NOV 14 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

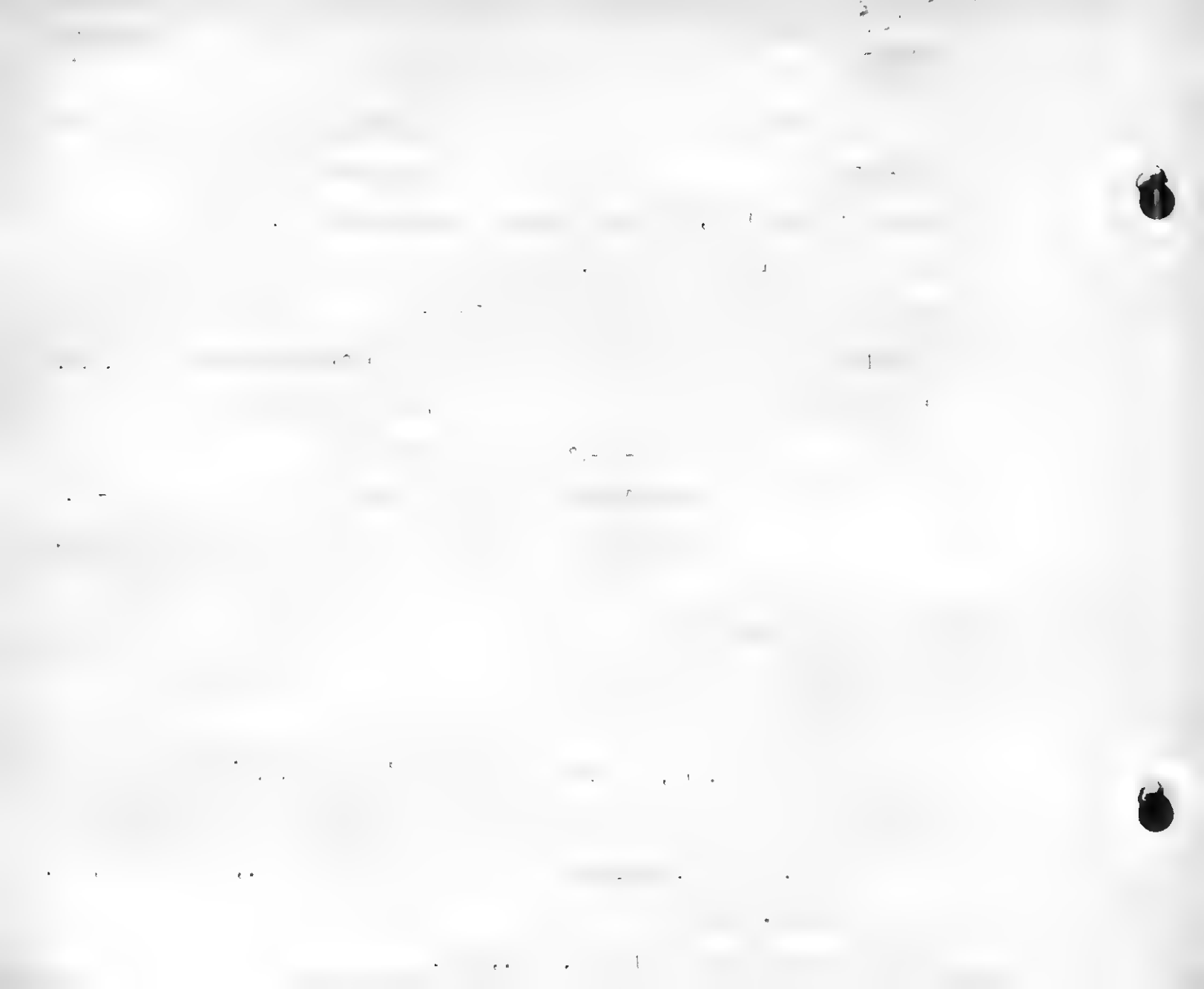
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14715

CERTIFICATE OF DEATH

14726

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 60 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL, 900 SETON DRIVE				d. STREET ADDRESS 702 MARYLAND AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ESTELLA E. HINER				4. DATE OF DEATH NOVEMBER 17 1967				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-20-02		
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA (ROMNEY)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES MESSICK				14. MOTHER'S MAIDEN NAME IDA MAE RODERICK				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO 220-34-1326		17. INFORMANT HOSPITAL RECORD			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE STOMACH 151X DUE TO CACHEXIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO							INTERVAL BETWEEN DEATH AND DEATH 6 MO.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) NONE					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from APRIL 28, 1967 to NOV. 17, 1967 , that (I) (we) saw the deceased alive on NOV. 17, 1967 , and that death occurred at 9:30 A.M. from causes and on the date stated above.								
22a. SIGNATURE <i>James P. Hallinan M.D.</i>				22b. DATE SIGNED 11-18-67				
22c. PHYSICIAN'S NAME (Type) DR. JAMES P. HALLINAN				22d. ADDRESS 140 BEDFORD ST., CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 20, 1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany, Md.		
24. FUNERAL DIRECTOR SCARPELLI FUNERAL HOME				25a. REC'D BY REGISTRAR 108 VA. AVE., CUMB.		25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>		
				DATE NOV 27 1967				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

3

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
14716											
14727											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG				c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outs de corporate limits, write RURA. and give nearest town) FROSTBURG					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 74 FROST AVENUE						d. STREET ADDRESS 74 FROST AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last F. JOSEPHINE HOLBEN						4. DATE OF DEATH Month Day Year NOVEMBER 27, 1967					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 12, 1876		9. AGE (In years lost birthday) 91 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN S. METZGER						14. MOTHER'S MAIDEN NAME FLORENCE KELLER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address MRS. RICHARD HOLBEN, FROSTBURG, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) arterio-sclerotic heart disease 444 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) Senility										INTERVAL BETWEEN ONSET AND DEATH 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial asthma											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-10 , 19 52 , to 11-27 , 19 67 , that (I) (we) last saw the deceased alive on 11-22 19 67 , and that death occurred at 5:40 A.M. from causes and on the date stated above.											
22a. SIGNATURE H. C. Diehl M.D.						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 11-28-67.			
22c. PHYSICIAN'S NAME (Type) H. C. DIEHL, M. D.						22d. ADDRESS W. MAIN ST., FROSTBURG, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 30 1967		23c. NAME OF CEMETERY OR CREMATORY FBG. MEMORIAL PARK				23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.			
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532						25a. REC'D BY REGISTRAR DEC 1 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14728

14717

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MD.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McMullen Hwy				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McMullen Hwy			
d. NAME Home R.F.D. 3 Box 36 Rawlings				d. STREET ADDRESS R.F.D. 3 Box 36 Rawlings			
3. NAME OF DECEASED (Type or print) Virginia Rose House				4. DATE OF DEATH Nov. 23, 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1915	9. AGE (In years last birthday) yrs 52	IF UNDER 1 YEAR Months 10 Days 4	IF UNDER 24 HRS Hours 10 Min 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Keyser, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Sherwood Barrett				14. MOTHER'S MAIDEN NAME Nellie Gerard (Elizabeth)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 235-16-1491		17. INFORMANT Address Lewis T. House - (Husband)			
18. CAUSE OF DEATH (Enter only one cause per PART. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4 xvi DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, CORONARY SCLEROSIS DUE TO ---				INTERVAL BETWEEN ONSET AND DEATH SUDDEN			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic M.D. EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				22. DATE SIGNED 11-23-67 CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-25-67		23c. NAME OF CEMETERY OR CREMATORY Potomac Valley N. Park		23d. LOCATION (City or town) (County) (State) Keyser, W. Va.	
24. FUNERAL DIRECTOR Thomas Smith Jr. ADDRESS Keyser, W. Va.				25a. REC'D BY REG. EXAM. NOV 27 1967		25b. REGISTRAR'S SIGNATURE John W. Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15
20M 1/4

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
14718									
1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westernport c. LENGTH OF STAY IN 1b minutes d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bloomington d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Richard Leo Middle Howard, Sr.					4. DATE OF DEATH Nov. 18 Month Nov. Day 18 Year 1967				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 15, 1902		9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Digester Operator			10b. KIND OF BUSINESS OR INDUSTRY Paper Mill			11. BIRTHPLACE (County & State, or foreign country) Garrett-Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James G. Howard					14. MOTHER'S MAIDEN NAME Martha O'Neil				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 217-09-1754A		17. INFORMANT Ada Howard-Bloomington, Md.			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 2 hours	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on Nov 15 19 67 , and that death occurred at 7:30 M, from the causes and on the date stated above.									
22a. SIGNATURE J. H. Wolverton Jr.					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) J. H. Wolverton Jr.					22d. ADDRESS Piedmont, W. Va.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 11/21/67		23c. NAME OF CEMETERY OR CREMATORY Bloomington		23d. LOCATION (City, town or county) (State) Bloomington Md.		
24. FUNERAL DIRECTOR J. F. Bral ADDRESS Westernport, Md.					25a. REC'D BY REGISTRAR NOV 22 1967 DATE		25b. REGISTRAR'S SIGNATURE James F. Judge		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

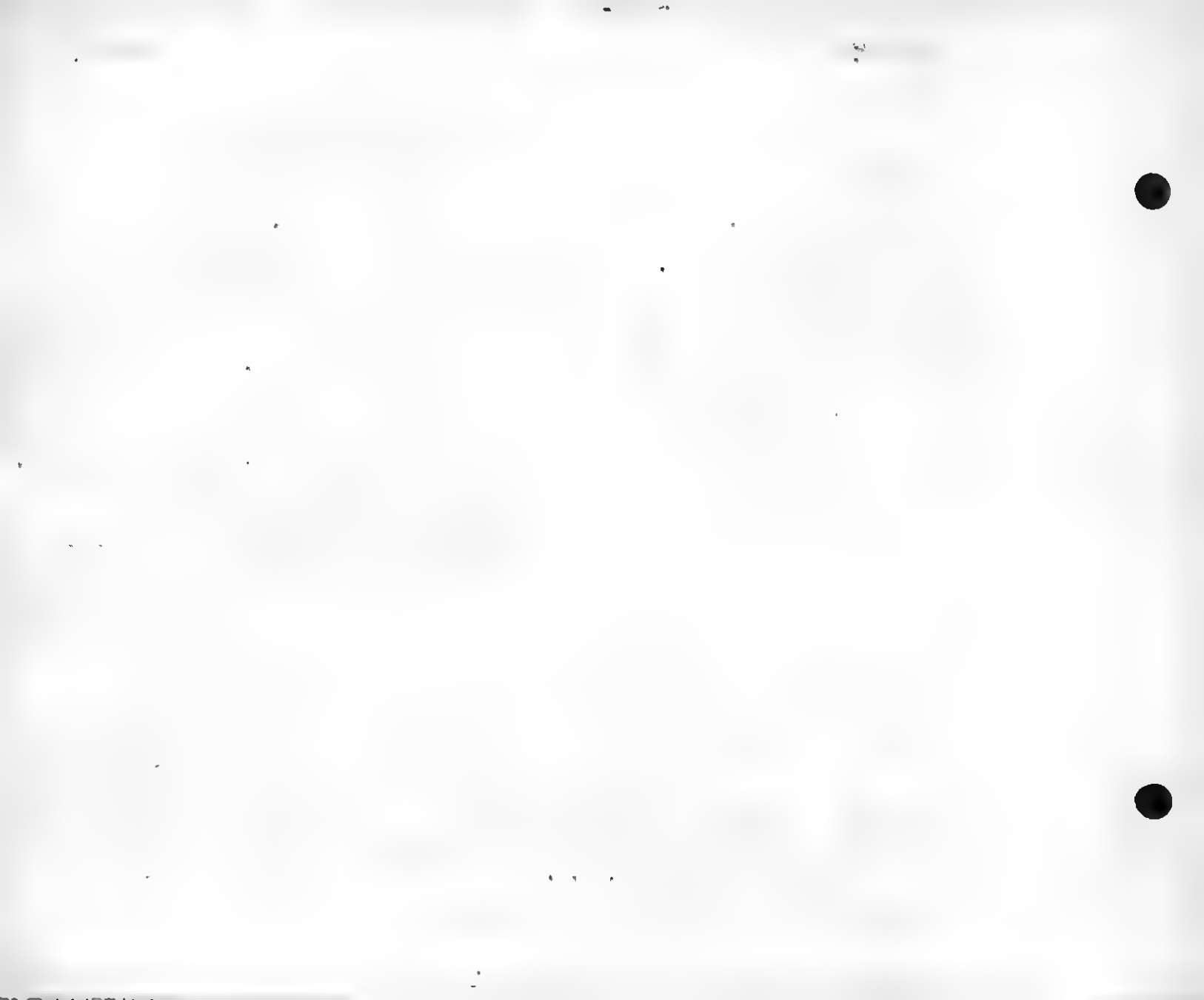
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14719

14730

1 PLACE OF DEATH a COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE Maryland b COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Douglas Ave.		e STREET ADDRESS Douglas Ave.	
3 NAME OF DECEASED (Type or print) JAMES W. HUTCHESON		4 DATE OF DEATH Month 11 Day 14 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11/25/1899
9 AGE (In years lost birthday) 68 yrs.		10 IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-County Road Employee		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Lonaconing, Md.		12 CIT ZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME John Hutcheson		14. MOTHER'S MAIDEN NAME Bessie De Vault	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT William Hutcheson, Lonaconing, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH; BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 11/14/1967		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Cumberland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/17/1967	23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	23d. LOCATION (City or town) (County) (State) Lonaconing, Md.
24. FUNERAL DIRECTOR GEORGE EICHHORN		25a. REC'D BY REGISTRAR NOV 20 1967	
ADDRESS Lonaconing, Md.		25b. REGISTRAR'S SIGNATURE <i>William J. Jones</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

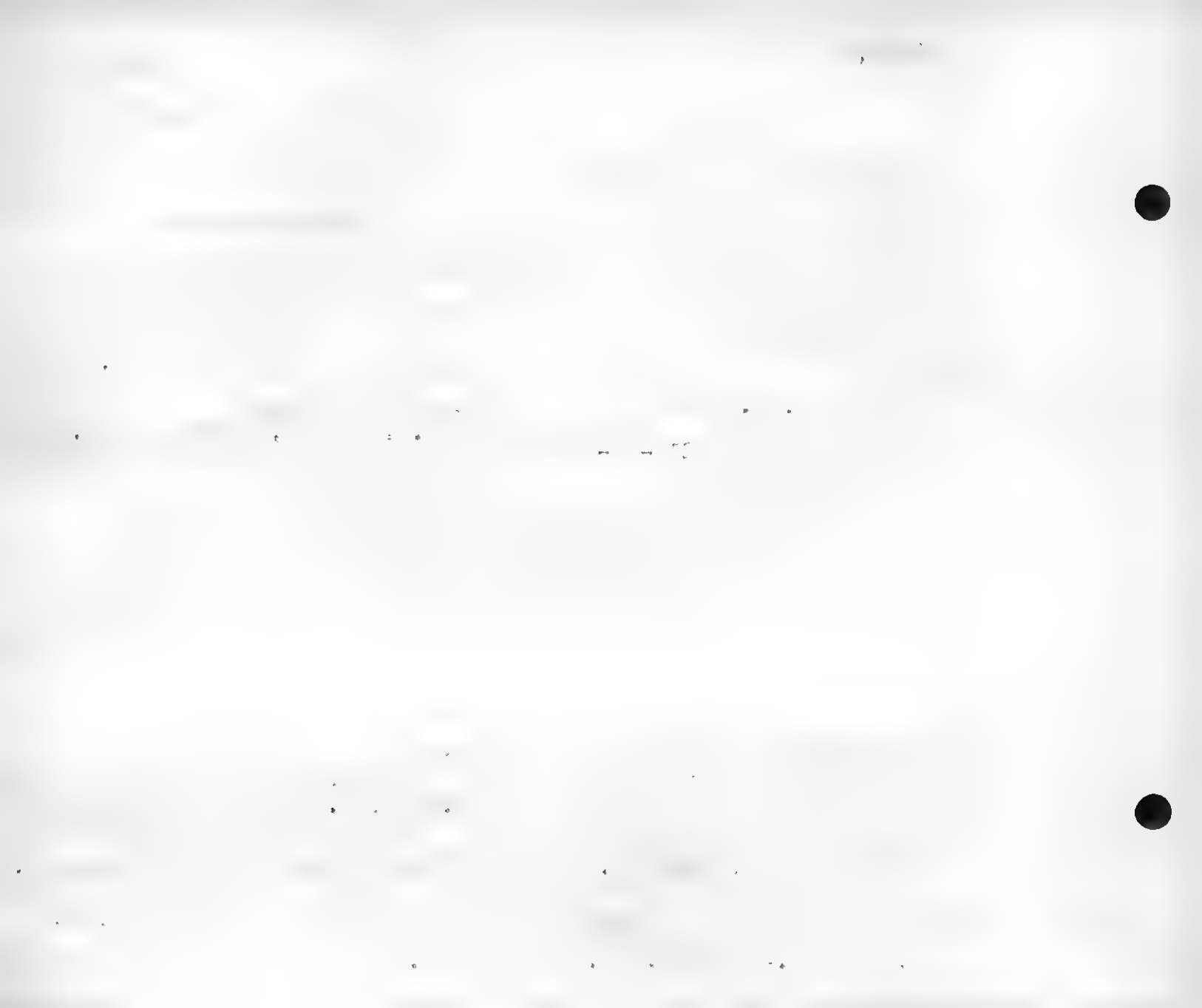
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14730

CERTIFICATE OF DEATH

14731

1. PLACE OF DEATH a COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c LENGTH OF STAY IN TB 1/9/1960	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last William Bernard Kelley		4. DATE OF DEATH Month Day Year November 11, 1967	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12/29/1911
9 AGE (In years last birthday) 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James M. E. Kelley	
14. MOTHER'S MAIDEN NAME Amelia M. Beale		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO 214-07-5457		17. INFORMANT P.O. Box 599, Cumberland, Md. 21502 Allegany County Infirmary records.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acute Chronic Uremic Toxemia DUE TO (c) Gen. arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/9/1960 , 19 11/11/1967 , that (I) (we) last saw the deceased alive on 11/11/1967 , and that death occurred at P. M, from causes and on the date stated above.			
22a SIGNATURE George M. Simons		22b DATE SIGNED 11/13/1967	
22c PHYSICIAN'S NAME (Type) George M. Simons, M.D.		22d ADDRESS Memorial Hospital, Cumberland, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 11/14/67	23c NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR John J. Hafer, Jr., 230 Balto. Ave., Cumberland, Md.		25a REC'D BY REGISTRAR NOV 15 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14721

14732

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b Cumberland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hosp.			d. STREET ADDRESS 208 N. Center Street		
3. NAME OF DECEASED (Type or print) Margaret E. Kenny			4 DATE OF DEATH Month Nov. Day 20 Year 1967		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 2, 1884		9 AGE (in years lost birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Lonoconing Md.	
13. FATHER'S NAME Edward Kenny			14. MOTHER'S MAIDEN NAME Miss Sadie Kenny Cumberland Md.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Sadie Kenny Cumberland Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema Hydrothorax DUE TO (b) Shock Anemia DUE TO (c) Bleeding Peptic Ulcer			INTERVAL BETWEEN ONSET AND DEATH Days		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of Left Hip			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fall in Hallway of her home			
20c. TIME OF INJURY Month, Day, Year 11/23/67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Home	20f. (City or town) Cumberland, Alleg. Md.	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitaralis M.D.			22. DATE SIGNED Nov 22, 1967		
EXAMINER'S NAME (Type) Benedict Skitaralis			Address (Street, city, town, or county) Cumberland, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/23/67	23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cem.		23d. LOCATION (City or Town) Mt. Savage (County) Allegany (State) Md.	
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.			25a. REC'D BY REGISTRAR NOV 22 1967		25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #1205 11/29/67 ph
CERTIFICATE OF DEATH

14733

14722

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 610 MARYLAND AVENUE	
3. NAME OF DECEASED (Type or print) First CANDACE Middle E. Last KERNS		4. DATE OF DEATH Month NOVEMBER Day 18 Year 1967	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-1-1893
9 AGE (In years and months) 74 yrs		IF UNDER 1 YEAR Months Days	F UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State or foreign country) LARGENT W. VA.
13. FATHER'S NAME JOSEPH EATON		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure, Rt + left 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis + Hypertensive Heart Disease DUE TO (c) 104p		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic accident		19 WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from 11/18/67 to 11/18/67 that (I) (we) last saw the deceased alive on 11/18/67 and that death occurred at 5:27 PM from causes and on the date stated above		20f (City or town) (County) (State)	
22a SIGNATURE S. G. WEISMAN M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b DATE SIGNED 11/18/67
22c. PHYSICIAN'S NAME (Type) S. G. WEISMAN, M.D.		22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Nov. 21, 1967	23c NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany C.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a REC'D BY REGISTRAR NOV 27 1967	25b REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
14723		14734	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 1HR & 25MI		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS LIVES IN CORRIGANVILLE IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First MYRTLE Middle F. Last LOCKARD		4. DATE OF DEATH Month NOVEMBER Day 3 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/12/94
9. AGE (in years last birthday) yrs 72		10. F UNDER 1 YEAR Months Days hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Hazen, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SMITH, RICHARD		14. MOTHER'S MAIDEN NAME , ELLA (Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) 10913			INTERVAL BETWEEN ONSET AND DEATH 4 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Congestive Heart Failure, Diabetic Mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7:28 , 11-3 , 1967 that (I) (we) last saw the deceased alive on 11-2 , 1967 , and that death occurred at 11:40 AM , from causes and on the date stated above.			
22a. SIGNATURE William P. James		22b. DATE SIGNED 11/2/67	
22c. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES		22d. ADDRESS 441 N. CENTRE ST., CUMBERLAND, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 5, 1967	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION (City or town) (County) (State) Cumberland Allegany Md
24. FUNERAL DIRECTOR William G. Kight		25a. REC'D BY REGISTRAR NOV 14 1967	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE J. Carlos Jones	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14735

14724

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b. STATE Maryland c. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b Lonaconing	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Detmold Street		d. STREET ADDRESS Detmold Street	
3. NAME OF DECEASED (Type or print) JOHN MAC NAMARA		4. DATE OF DEATH Month Day Year 11/21/1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/22.1897
9. AGE (In years last birthday) 70 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret. red) Retiree Postal Clerck Railroad	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Mac Namara		14. MOTHER'S MAIDEN NAME Minnie Conroy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 041-1892698	
17. INFORMANT Rella Mac Namara, Lonaconing, Md.		Address (WIFE)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Coronary Sclerosis (b) (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CA. EXAMINER <input type="checkbox"/> DEPUTY MED. CA. EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		DATE SIGNED 11/21/1967 Address (Street, city, town or county) Cumberland, Md.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 11/23/1967	23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery	23d. LOCATION (City or town) (County) (State) Lonaconing, Md.
24. FUNERAL DIRECTOR George Eichhorn		25a. REC'D BY REGISTRAR NOV 27 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

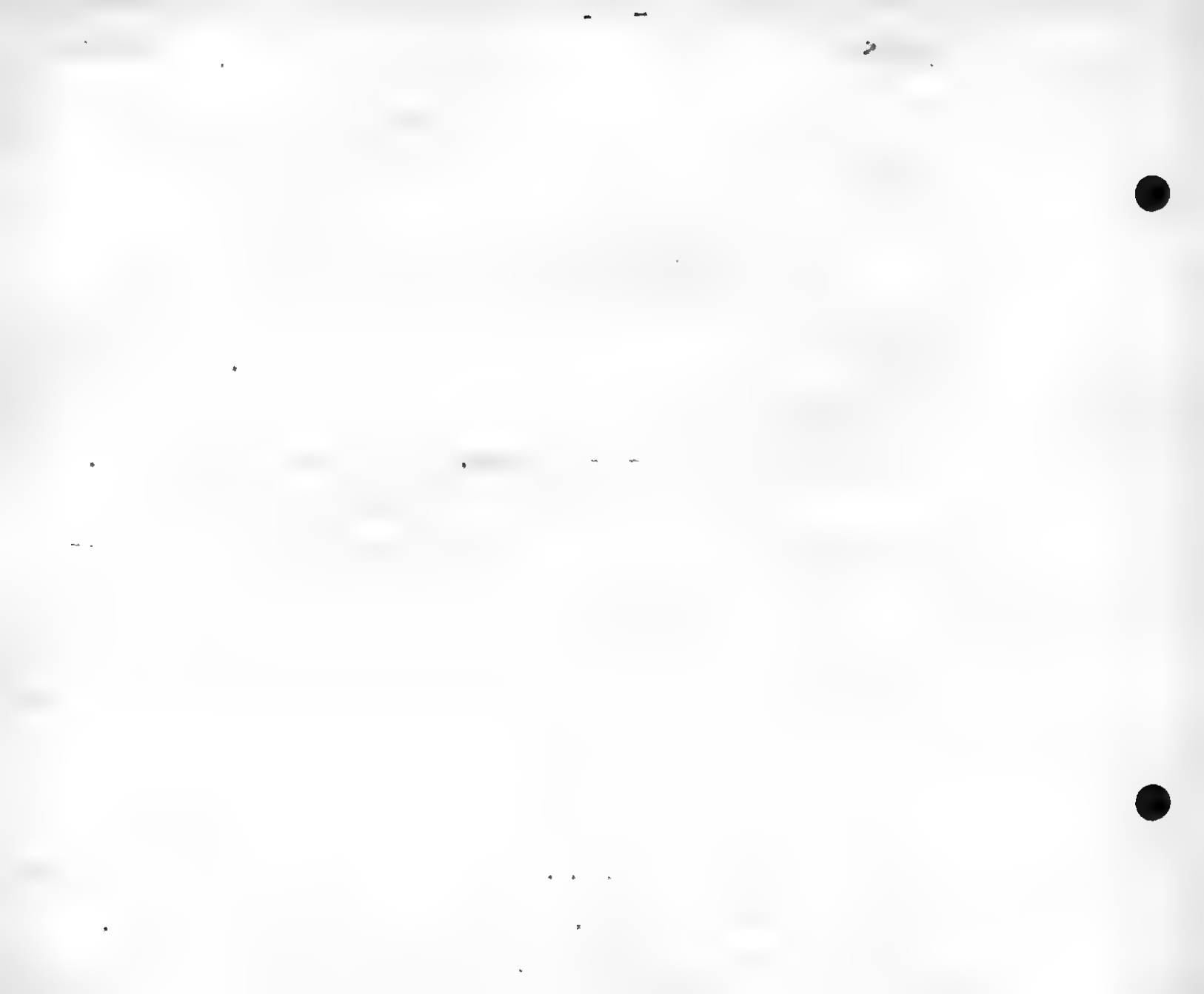
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14725

14736

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		c. LENGTH OF STAY IN 1b Midland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) James De Sales Maher		4 DATE OF DEATH 11/27/1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/23/1895
9 AGE (In years last birthday) 72		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Vale Summitt, Md.	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME William Maher	
14 MOTHER'S MAIDEN NAME Mary Haththorne		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes-World War #1	
16 SOCIAL SECURITY NO. 219-36-9357		17 INFORMANT Mrs. Mary Maher, Midland, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Coronary Sclerosis DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelis M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 11/27/1967 DATE SIGNED	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/30/1967	23c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery	23d. LOCATION (City or town) (County) (State) Frostburg, Md.
24. FUNERAL DIRECTOR George Eichhorn		25a. REC'D BY REGISTRAR DEC 1 1967	
25b. REGISTRAR'S SIGNATURE Lonaconing, Md.		25c. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 7 and 8, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14726

CERTIFICATE OF DEATH

14737

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hosp.				d. STREET ADDRESS 339 CITY VIEW TERRACE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last CAROLINE FLORENCE MARTIN				4 DATE OF DEATH Month Day Year NOVEMBER 14, 1967			
5 SEX FEMALE		6 COLOR OR RACE WHITE		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 8-22-84	
9 AGE In years (rthday) yrs 83		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) CUMB, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AMBROSE RICKER				14. MOTHER'S MAIDEN NAME MARGARET J. CONNERS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO (b) Chronic Heart Condition DUE TO (c) Cerebral Vascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 13, 1967 to Nov 14, 1967 , that (I) (we) last saw the deceased alive on Nov 14, 1967 , and that death occurred at 4:55 P.M. from causes and on the date stated above.							
22a. SIGNATURE DR. G. O. HIMMELWRIGHT				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/16/67	
22c. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT				22d. ADDRESS CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/17/67		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR H. Wayne George Cumb. Md.				25a. REC'D BY REGISTRAR DATE NOV 20 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14727

CERTIFICATE OF DEATH

14738

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN IL 66 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3 NAME OF DECEASED (Type or print) First Middle Last MAZA G. MC COY		4 DATE OF DEATH Month Day Year 11 27 19 67	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/22/1889
9 AGE (In years last birthday) yrs 78		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (County & State, or foreign country) PENNA.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID C. MILLER		14. MOTHER'S MAIDEN NAME XX CATHERINE ROBINETTE	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO NONE	
17 INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RT Hemiplegia & Aphasia DUE TO (b) Arteriosclerosis cerebral DUE TO (c) fever Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH few hrs few mo	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-22-67 , 19 67 , that (I) (we) last saw the deceased alive on 11-21-67 , and that death occurred at 12:49 AM , from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. SAMUEL H. JONES		22d. ADDRESS 50 PERSHING ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 29 NOV 67	23c. NAME OF CEMETERY OR CREMATORY CENTERVILLE CEMT.	23d. LOCATION (City or Town) (County) (State) CENTERVILLE, BEDFORD PENNA.
24 FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR STREET CUMBERLAND		25a. REC'D BY REGISTRAR NOV 30 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular pages 1, 2, and 3 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14728

14739

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c LENGTH OF STAY IN 1b 1 1/2 DAYS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS 73 OLMOND STREET	
3 NAME OF DECEASED (Type or print) PATRICK ROBERT McKENZIE		4. DATE OF DEATH Month NOVEMBER Day 10 Year 19 67	
5. SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 14, 1896
9 AGE (In years last birthday) yrs. 71		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY CELANESE CORP.	11 BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA
13. FATHER'S NAME PATRICK McKENZIE		14. MOTHER'S MAIDEN NAME RACHEL HUTZELL	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW1		16 SOCIAL SECURITY NO 217-10-6121	
17. INFORMANT MRS. GERTRUDE McKENZIE, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Failure 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary emphysema DUE TO (c) arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 3 days years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/8 , 19 67 , to 11/10 , 19 67 that (I) (we) last saw the deceased alive on 11/10 19 67 , and that death occurred at 4A M, from causes and on the date stated above.			
22a SIGNATURE John B. Davis		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b DATE SIGNED 11/10/67
22c PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M. D.		22d ADDRESS 2 BROADWAY, FROSTBURG, MD.	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF NOV. 13 '67	23c NAME OF CEMETERY OR CREMATORY ST. ANN'S CEMETERY	23d LOCATION (City or Town) (County) (State) GARRETT COUNTY
24 FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532		25a. REC'D BY REGISTRAR DATE NOV 14 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	

14726

CERTIFICATE OF DEATH

14740

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c LENGTH OF STAY IN 1b 9 DAYS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART		d STREET ADDRESS 106 DECATUR ST.	
3. NAME OF DECEASED (Type or print) FRANK First H. Middle MC MILLAN Last		4 DATE OF DEATH NOVEMBER Month 18 Day 1967 Year	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-7-97
9 AGE (In years last birthday) 70 yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROADING		10b KIND OF BUSINESS OR INDUSTRY RAILROAD	
11 BIRTHPLACE (County & State, or foreign country) ALLEGANY CTY., MARYLAND		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME CHARLES Mc Millan		14. MOTHER'S MAIDEN NAME MERLE ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. 705-09-3519	
17. INFORMANT HOSPITAL RECORD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cox Pulmonale with Heart Failure DUE TO Post-radiation Scarring, Rt Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, Rt. Lung (c) Carcinoma, Rt. Lung			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-9 , 1967, to 11-18 , 1967, that (I) (we) last saw the deceased alive on 11-18 , 1967, and that death occurred at 11-18 M, from causes and on the date stated above.			
22a. SIGNATURE Calvin G. Hadidian		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) CALVIN HADIDIAN		22d. ADDRESS ALGONQUIN HOTEL, CUMBERLAND, MD.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Nov. 21, 1967	23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park	23d LOCATION (City or Town) (County) (State) Frostburg, Md. Allegany
24 FUNERAL DIRECTOR SCARPELLI FUNERAL HOME		25a REC'D BY REGISTRAR NOV 22 1967	
ADDRESS CUMBERLAND, MD.		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14730

14741

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND		c. LENGTH OF STAY IN TB 13 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND		d. STREET ADDRESS 412 LOUISIANA AVENUE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) DELLA MARY MEAGHER		4. DATE OF DEATH Month NOVEMBER Day 24 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/15/91
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months 12 Days 19 Hours 67 Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS		11b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	
11. BIRTHPLACE (County & State, or foreign country) SHAFT, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDGAR MEAGHER		14. MOTHER'S MAIDEN NAME MORGAN, MARGARET	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 213-01-5956	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart attack with embolism DUE TO through blood Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1966 to Nov 24, 1967 that (I) (we) last saw the deceased alive on Nov 23, 1967 and that death occurred at 4:30 AM from causes and on the date stated above.			
22a. SIGNATURE DR. B. SCHINDLER		22b. DATE SIGNED 11/24/67	
22c. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER		22d. ADDRESS CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/27/67	
23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY		23d. LOCATION (City or Town) (County) (State) FROSTBURG MARYLAND	
24. FUNERAL DIRECTOR WILLIAM M. SOWERS		25a. RECEIVED BY REGISTRAR NOV 29 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14731

CERTIFICATE OF DEATH

16250

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2/9/1967	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Anna Middle Elizabeth Last Mellott		4 DATE OF DEATH Month November Day 29 , Year 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/24/1894
9 AGE (in years last birthday) 73		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) Somerset County, Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Herman Hosselrode		14. MOTHER'S MAIDEN NAME Jennie Fechner 21502	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT P.O. Box 599, Cumberland, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cerebrovascular accident DUE TO 445A Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerosis DUE TO (c) Chr. Hypertensive C.V. D	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION, GIVEN IN PART I (a) Diabetes Mellitus, Obesity, ECG. Left hemiplegia 12/66		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF DEATH Month, Day, Year Hour 0 m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 9, 1967 to Nov. 29, 1967 at (I) (we) last saw the deceased alive on Nov. 29, 1967 , and that death occurred at P. M. from causes and on the date stated above.			
22a. SIGNATURE John A. Topper M.D.		22b. DATE SIGNED Dec 1-1967	
22c. PHYSICIAN'S NAME (Type) John A. Topper		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	
Burial	Dec. 2, 1967	Pale Alto Cemetery	
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa.		25a. RECEIVED BY REGISTRAR DEC 7 1967	25b. REGISTRAR'S SIGNATURE Charles Judge RD
23d. LOCATION (City or town) (County) (State) Hyndman, Pa. Bedford Co.			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14738

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14742

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE W.Va. b. COUNTY Mineral	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY N 1b -----	c. CITY OR TOWN (If outside of corporate limits write RURAL and give nearest town) Keyser
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital---DOA		d. STREET ADDRESS Rt. # 2	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Walter C Middle Metcalf Last		4 DATE OF DEATH Month November Day 4 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7 Dec 1911
9 AGE (In years last birthday) 55		10 UNDER 1 YEAR Months Days	11 UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector RR		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11 BIRTHPLACE (State or foreign country) West Virginia
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jacob Metcalf	
14. MOTHER'S MAIDEN NAME Margaret Ellifritz		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 44	
16 SOC. A. SECURITY NO.		17 INFORMANT Margaret Metcalf Address RD 2 Keyser, W. Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis, Right DUE TO 4401 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Intimal Hemorrhage DUE TO (c) Coronary Sclerosis, Marked		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED November 4, 1967		DEPUTY MEDICAL EXAMINER XX Address (Street, city, town, or county) Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7 Nov 1967	23c. NAME OF CEMETERY OR CREMATORY Thrush	23d. LOCATION (City or Town) (County) (State) Antioch, Mineral W.Va.
24. FUNERAL DIRECTOR Allen M. Rotruck Address Keyser, W. Va.		25a. REC'D By REG STRAR DATE Nov 7 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14733

14743

1 PLACE OF DEATH a COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c LENGTH OF STAY IN 1b 34 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 74 FROST AVENUE	
3 NAME OF DECEASED (Type or print) First JOHN Middle B Last METZGER		4 DATE OF DEATH Month NOVEMBER Day 1 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-19---84
9. AGE (In years last birthday) 83 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED AGENT	
11 BIRTHPLACE (County & State, or foreign country) FROSTBURG, MD.		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN S. METZGER		14 MOTHER'S MAIDEN NAME FLORENCE KELLER	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16 SOCIAL SECURITY NO 214-05-4821	
17 INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sudden cardiac arrest DUE TO (b) Chronic latent cardiac decompensation DUE TO (c) A.S. cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH 3 months 17 years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recurrent Papilla Carcinoma Bladder, 5 years Chronic About?			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1942 , 1950, to 1 Nov. , 1967, that (I) (we) last saw the deceased alive on 1 Nov. , 1967, and that death occurred at 8:40 p.m. on the date stated above			
22a. SIGNATURE W. Alfred van Ormer		22b. DATE SIGNED 7 Nov. 67	
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF NOV. 4 '67	23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532		25a. REC'D BY REGISTRAR DATE NOV 9 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

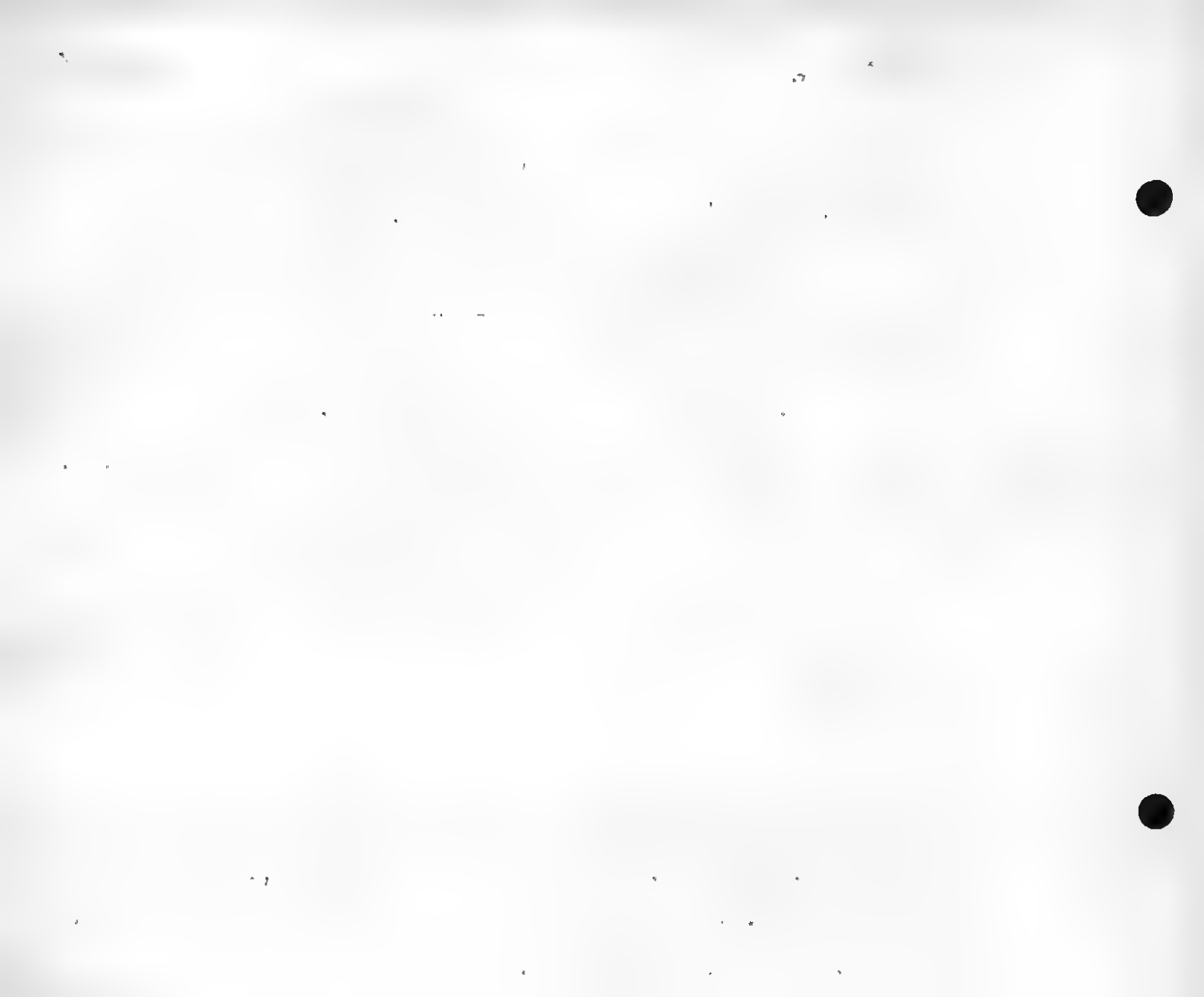
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14734

CERTIFICATE OF DEATH

14744

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6HRS 10MIN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS P.O. BOX 48 CHURCH ST.	
3 NAME OF DECEASED (Type or print) First DONALD Middle ARTHUR Last MILLER		4 DATE OF DEATH Month NOVEMBER Day 5 Year 1967	
5 SEX MALE	6. COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-28-1967
9 AGE (in years last birthday) yrs 8 Months 8		IF UNDER 1 YEAR Days 8 Hours 8 Mins 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND		12. COUNTRY OF WHAT COUNTRY? USA	
13. FATHER'S NAME DAVID A. MILLER		14. MOTHER'S MAIDEN NAME BARBARA J. BOHN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) pneumonia 2890 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hunter's Syndrome DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 6:50 PM from causes and on the date stated above.			
22a. SIGNATURE <i>Robert J. Dawson</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. ROBERT J. DAWSON		22d. ADDRESS 500 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, or other disposition BURIAL		23b. DATE THEREOF NOV. 8, 1967	
23c. NAME OF CEMETERY OR CREMATORY Lybarger Cemetery		23d. LOCATION (City or Town) (County) (State) Buffalo Mills, Pa. RD#1	
24. FUNERAL DIRECTOR HARVEY H. ZEIGLER, HYNDMAN, PA.		25a. REC'D BY REGISTRAR DATE NOV 13 1967	
25b. REGISTRAR'S SIGNATURE <i>James Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14735

CERTIFICATE OF DEATH

14745

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if inst. lnt on Residence before adm ssion) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. STREET ADDRESS 217 W. MAIN STREET	
3. NAME OF DECEASED (Type or print) First LULU Middle MINNICK Last		4. DATE OF DEATH Month NOVEMBER Day 1 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 19, 1900
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PETER CATON		14. MOTHER'S MAIDEN NAME CLARA McKENZIE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NONE		16. SOCIAL SECURITY NO NONE	
17. INFORMANT MRS. ETHEL McKENZIE, RT. 2, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE POSTERIOR MYOCARDIAL INFARCTION DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 7 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from OCT 27 , 19 67 , to Nov. 1 , 19 67 that (I) (we) last saw the deceased alive on OCT. 31 , 19 67 and that death occurred at 10:20 AM , from causes and on the date stated above.	
22a. SIGNATURE G. Paige Strong		22b. DATE SIGNED Nov. 1, 1967	
22c. PHYSICIAN'S NAME (Type) A. PAIGE STRONG, M.D.		22d. ADDRESS 167 E. MAIN ST., FROSTBURG, MD.	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 3, 1967	
23c. NAME OF CEMETERY OR CREMATORY McKENZIE CEMETERY		23d. LOCATION (City or Town) (County) (State) GARRETT COUNTY, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532		25a. REC'D BY REGISTRAR NOV 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial trans't permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

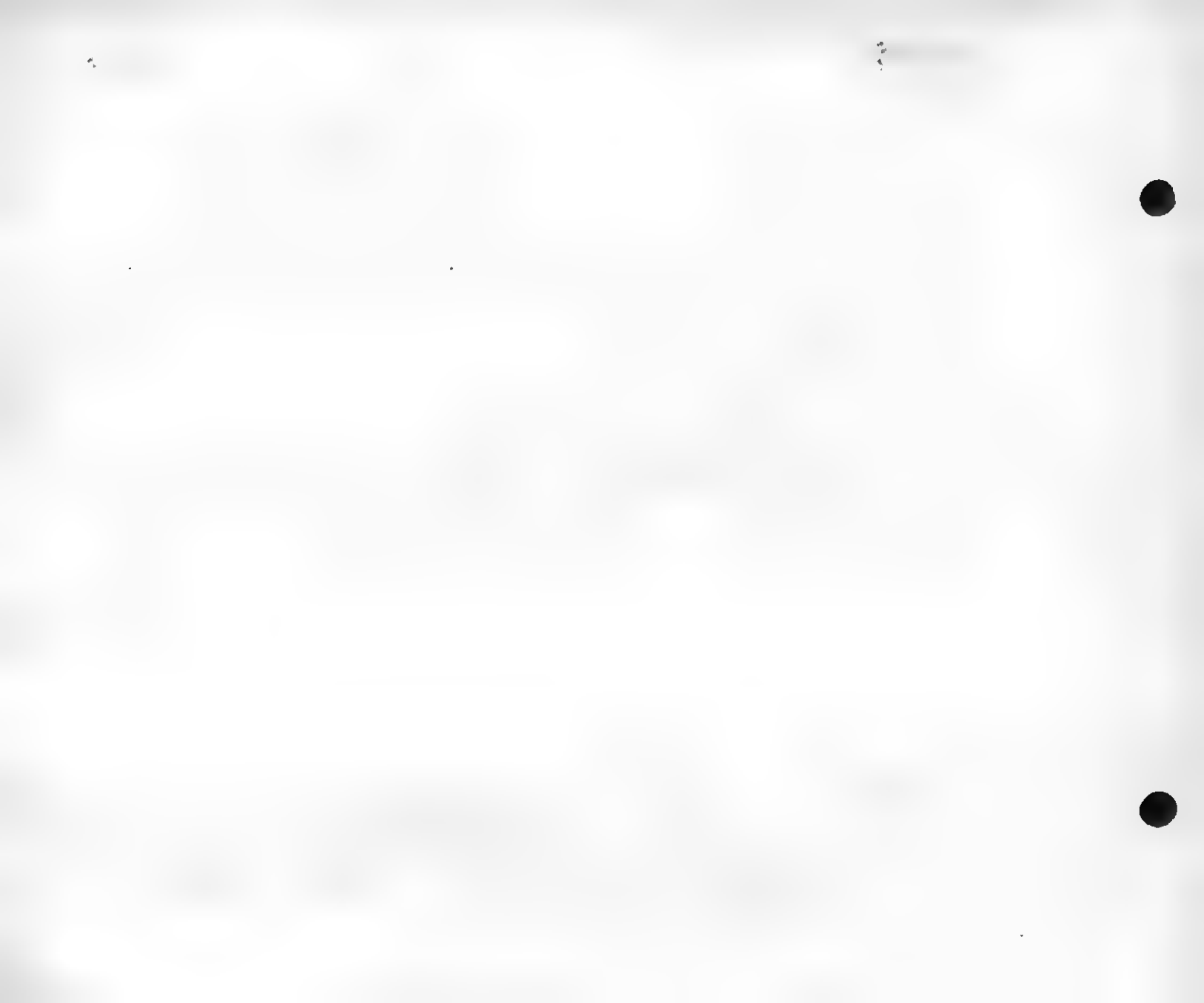
14736

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14746

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b LIFETIME	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. STREET ADDRESS 91 WRIGHT STREET	
3. NAME OF DECEASED (Type or print) First MATILDA Middle ELIZABETH Last MONAHAN		4. DATE OF DEATH Month NOVEMBER Day 25 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 30, 1889
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months 2 Days 1 Hours 0 Min. 0	
11a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSHUA SPERRY		14. MOTHER'S MAIDEN NAME DORA ALTMILLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO N.A.		16. SOCIAL SECURITY NO 220-52-9867	
17. INFORMANT MRS. CARL CLARK		Address FROSTBURG, MARYLAND 91 WRIGHT STREET	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO recurrent 3 times Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 2 months (b) AHCVR disease DUE TO years (c) years		INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct - , 19 67 to Nov 25 19 67 that (I) (we) last saw the deceased alive on Nov 25 19 67 , and that death occurred at 1 A. M. from causes and on the date stated above			
22a. SIGNATURE John B. Davis, M.D.		22b. DATE SIGNED 11/26/67	
22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M.D.		22d. ADDRESS 2 BROADWAY, FROSTBURG, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF NOV. 27, 1967	23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEM.	23d. LOCATION (City or Town) (County) (State) FROSTBURG MARYLAND
24. FUNERAL DIRECTOR MARILYN M. SOWERS		25a. REC'D BY REGISTRAR NOV 29 1967	
25b. REGISTRAR'S SIGNATURE Charles Yunge		25c. REGISTRAR'S NAME CHARLES YUNGE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14737

14747

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL) CUMBERLAND		c. LENGTH OF STAY IN lb 1 DAY	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 305 ARCH ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First NELLIE Middle W. Last MORRISON			4. DATE OF DEATH Month NOVEMBER Day 23 Year 1967		
5 SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-5-1896		9. AGE (In years last birthday) yrs 71
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA	
13. FATHER'S NAME LEWIS BUCKHOLDER			14. MOTHER'S MAIDEN NAME ZUELLA DEWITT		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 218-38-0344		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suggestive Heart Failure DUE TO (b) Arteriosclerotic Cerebrovascular Disease DUE TO (c) 5 yr Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 5 yr
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY, Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cum	(County) Allegany	(State) MD
21. I certify that (I) (this hospital) attended the deceased from 11/21/67 , 19 5:30 P.M. , 19 67 that (I) (was) last saw the deceased alive on 11/23/67 , 19 67 , and that death occurred at _____ M, from causes and on the date stated above					
22a. SIGNATURE DR. R. J. WILLIAMS		22b. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22c. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 26, 1967	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.			25a. REC'D BY REGISTRAR DATE NOV 28 1967		25b. REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

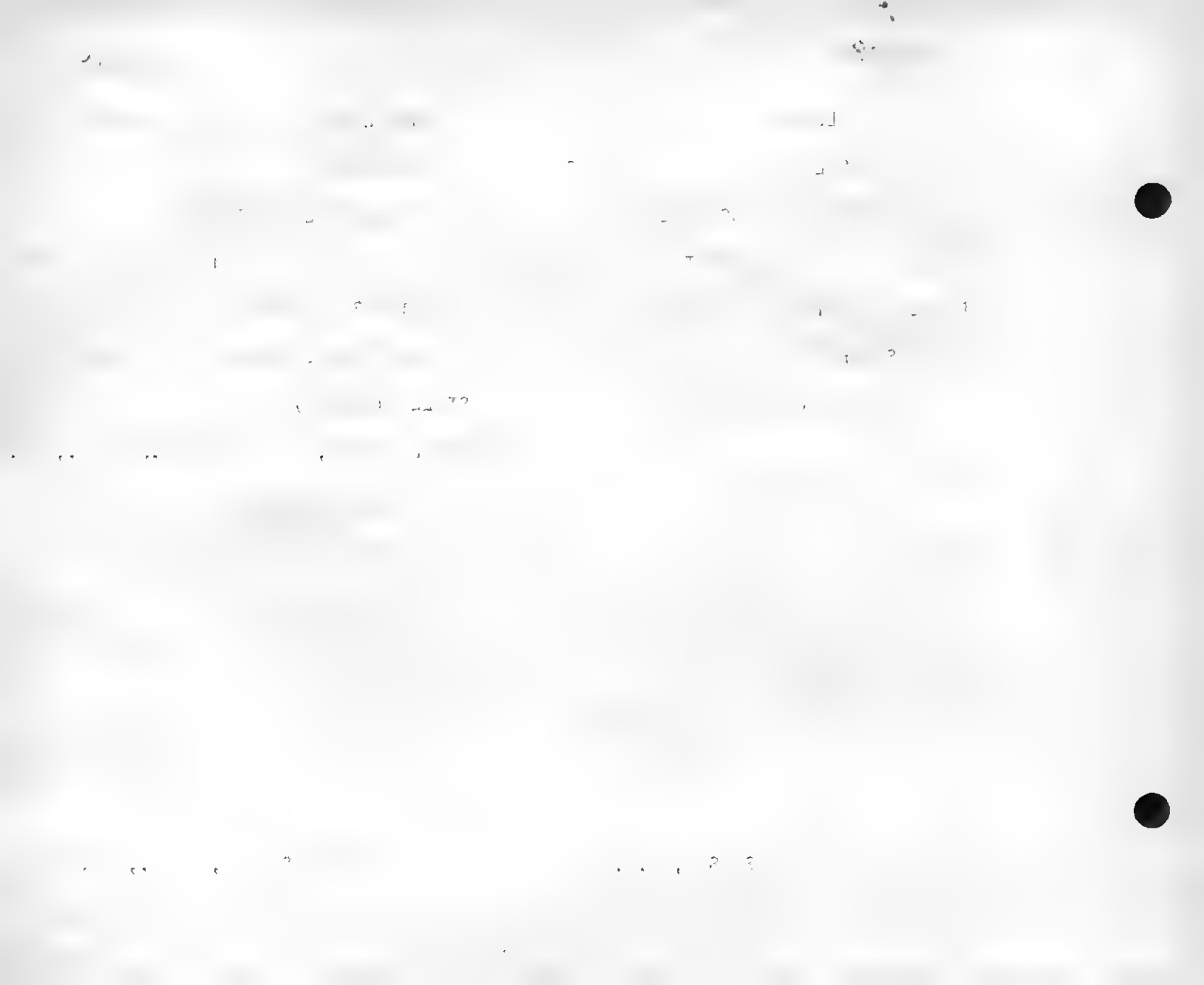
14738

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #8 & 9 info taken from birth cert.
Item #13 Film #G294 11, 18, 71 ph

CERTIFICATE OF DEATH

14748

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 8 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 316 CUMBERLAND STREET	
3 NAME OF DECEASED (Type or print) First MARGARET Middle Z Last NAVE		4 DATE OF DEATH Month 11 Day 02 Year 19 67	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/23/19 03-18-11/1500
9 AGE (In years, last birthday) 50		IF UNDER 1 YEAR Months 11 Days 02	IF UNDER 24 HRS. Hours 15 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME ALFRED ZILMAN Zihlman		14 MOTHER'S MAIDEN NAME STELLA (DURST)	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv.) NO		16. SOCIAL SECURITY NO	
17. INFORMANT HOSPITAL RECORD, 200 SETON DR., CUMB., M.D.		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident (cerebral embolus) DUE TO probably brain stem in location Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic duodenal ulcer with obstruction - status post-operative with vagotomy + gastrojejunostomy			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10-25 , 19 67 , to 11-2 , 19 67 , that (I) (we) last saw the deceased alive on 11-2 , 19 67 , and that death occurred at 10:15 PM , from causes and on the date stated above.			
22a SIGNATURE Andrew Stasko		22b. DATE SIGNED 11-2-67	
22c. PHYSICIAN'S NAME (Type) ANDREW STASKO, M.D.		22d. ADDRESS 401 DECATOR STREET, CUMB., M.D. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried	23b. DATE THEREOF 11/5/67	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Pl. Cumberland Md	23d. LOCATION (City or Town) (County) (State) Cumberland Md
24. FUNERAL DIRECTOR Louis Steen Inc. Cumberland Md		25a REC'D BY REGISTRAR NDV 6 1967	25b REGISTRAR'S SIGNATURE Charles Judge



7-1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14738

CERTIFICATE OF DEATH

14749

1. PLACE OF DEATH a. COUNTY ALLEGANY COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 83 W. COLLEGE AVE	
3. NAME OF DECEASED (Type or print) First DANIEL Middle HUGH Last NOLAN		4. DATE OF DEATH Month NOVEMBER Day 17 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-13-06
9. AGE (In years last birthday) yrs 61		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POSTAL CLERK		10b. KIND OF BUSINESS OR INDUSTRY POST OFFICE	
11. BIRTHPLACE (County & State, or foreign country) ALLEGANY FROSTBURG, MD. COUNTY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MICHAEL NOLAN		14. MOTHER'S MAIDEN NAME ELLEN (DURKIN)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 213-44-2035	
17. INFORMANT 900 SETON DRIVE HOSP. RECORD, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO RHEUMATIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET OF DEATH 6 WEEKS 40 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS A JTOPTSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 11-16 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 11-16 67		20f. (City or town) (County) (State) 11-17 67	
21. I certify that (I) (this hospital) attended the deceased from 11-16 67 , to 11-17 67 , that (I) (we) last saw the deceased alive on 11-16 67 , and that death occurred at 4 A M, from causes and on the date stated above.			
22a. SIGNATURE <i>Ralph B. Ballin</i> MD.		22b. DATE SIGNED 11-17-67	
22c. PHYSICIAN'S NAME (Type) DR. RALPH BALLIN		22d. ADDRESS 62 GREENE ST.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-20-67	
23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR DURST FUNERAL HOME		25a. REC'D BY REGISTRAR 57 FROST AVE FROSTBURG, MD.	
25b. REGISTRAR'S SIGNATURE <i>Orlando J. J...</i>		DATE NOV 21 1967	

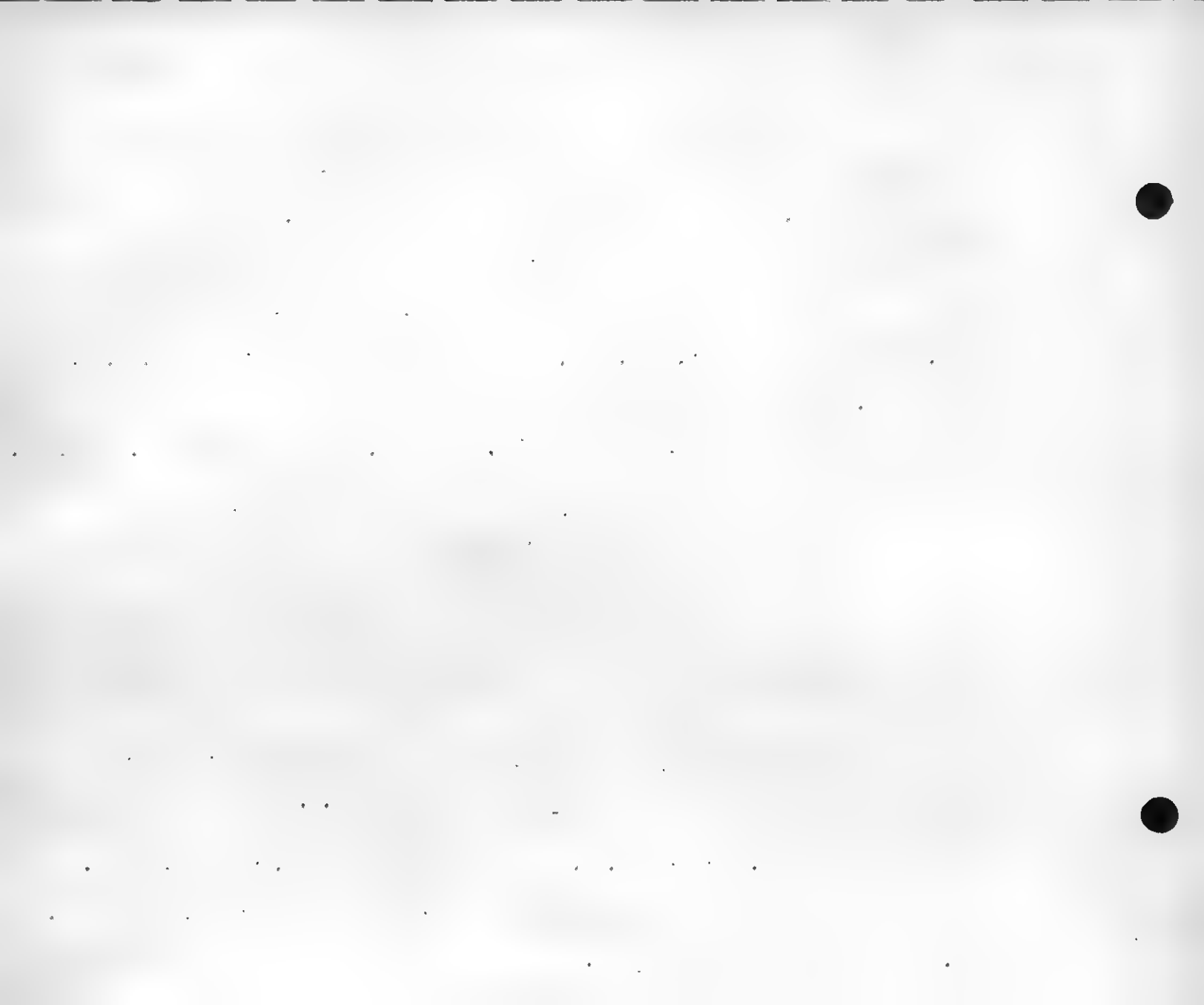
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VR A15 (4)
20M 1/65

14748
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14750

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE				b. COUNTY			
Allegany				Maryland				Allegany			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 306 Laing Ave.				d. STREET ADDRESS 306 Laing Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				Month Day Year			
First Middle Last Harry Stansbury Oss				November 30, 1967							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 27, 1899		9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. carman				10b. KIND OF BUSINESS OR INDUSTRY B. & O. Ry.		11. BIRTHPLACE (County & State, or foreign country) Cresaptown, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME George W. Oss				14. MOTHER'S MAIDEN NAME Hattie Winters							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 705-05-8525		17. INFORMANT Mrs. Cleona A. Oss		Address 306 Laing Ave. Cumb. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anemia DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 2 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Oct. 1, 1967 to Nov 30, 1967 that (I) (we) last saw the deceased alive on Nov 30, 1967, and that death occurred at 12:10, from the causes and on the date stated above.											
22a. SIGNATURE Clay E. Durrett				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> A.M.				22b. DATE SIGNED 12/1/67			
22c. PHYSICIAN'S NAME (Type) Clay E. Durrett, M.D.				22d. ADDRESS 236 Virginia Ave. Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/3/67		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland, Allegany Md.					
24. FUNERAL DIRECTOR H. Wayne George				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DEC 4 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

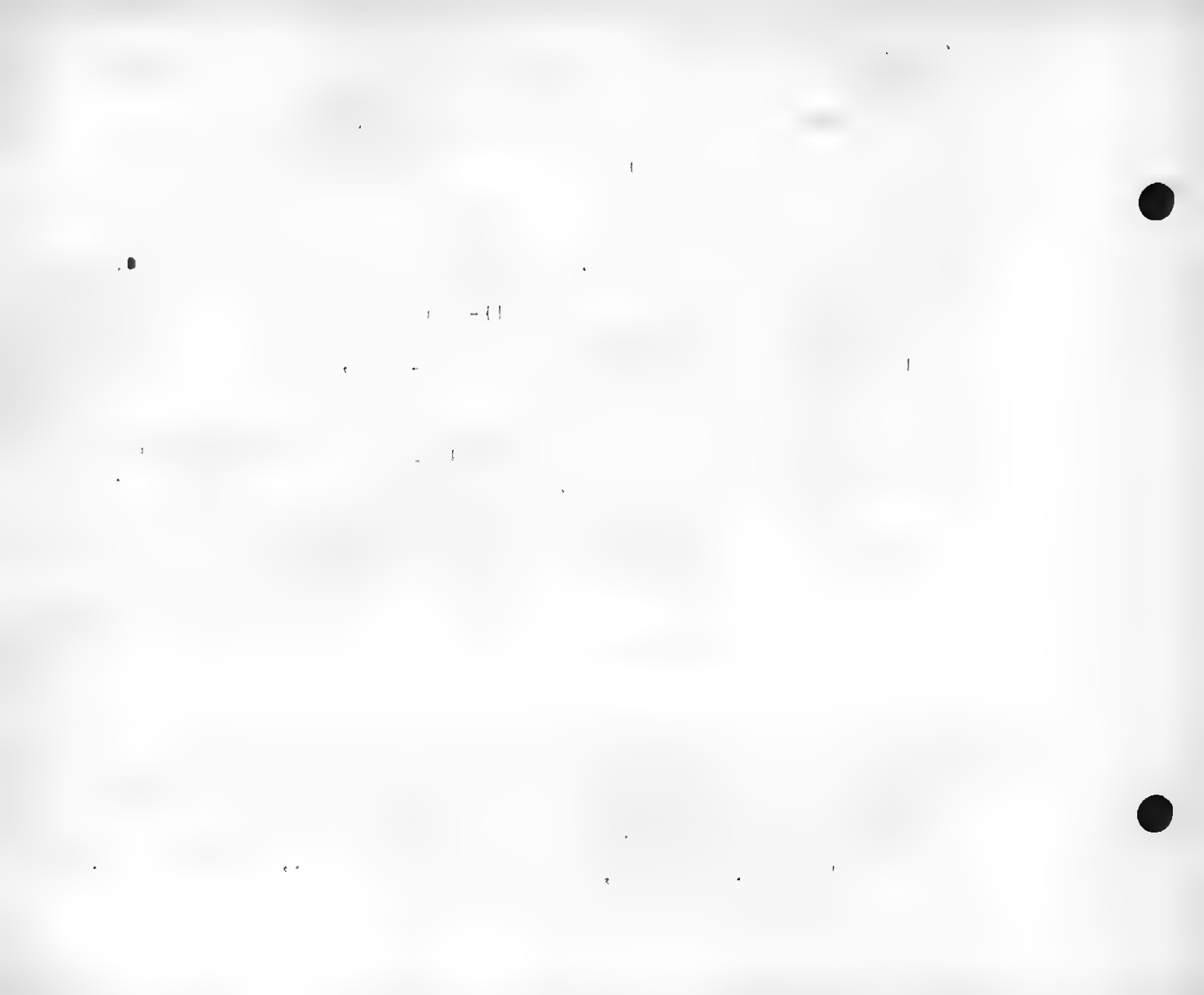
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14741

CERTIFICATE OF DEATH

16258

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10 HRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) (FRED) FREDERICK S. PALMER		4 DATE OF DEATH Month NOVEMBER Day 30 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-10-10
9. AGE (In years last birthday) yrs 57		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SILK WORKER		10b. KIND OF BUSINESS OR INDUSTRY CELANESE	
11. BIRTHPLACE (County & State, or foreign country) ALLEGANY, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES PALMER		14. MOTHER'S MAIDEN NAME ANNA DECKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO	
17. INFORMANT HOSPITAL CHART		Address SACRED HEART HOSPITAL 900 SETON DRIVE CUMBERLAND, MD 21502	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized massive Peritonitis DUE TO (b) Intestinal Obstruction of Colon DUE TO (c) Diverticulitis with Abscess Formation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Septic - Endotoxic Shock			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour "a.m." "p.m." 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 11-29-1967 , to 11-30-1967 , that (I) (we) last saw the deceased alive on 11-30-1967 , and that death occurred at 11-30-1967 M, from causes and on the date stated above.			
22a. SIGNATURE Richard E. Schindler		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) RICHARD E. SCHINDLER, MD		22d. ADDRESS 69 GREENE ST., CUMBERLAND, MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 4, 1967	23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cem.	23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DEC 7 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



14742

CERTIFICATE OF DEATH

14751

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c LENGTH OF STAY IN TB 11 DAYS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d STREET ADDRESS 85 EAST MAIN STREET	
3. NAME OF DECEASED (Type or print) PASQUALE P. PARISE		4. DATE OF DEATH NOVEMBER 28, 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MAY 29, 1920
9 AGE (In years last birthday) 47 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER LIQUOR & CUT-RATE	
10b KIND OF BUSINESS OR INDUSTRY STORE		11 BIRTHPLACE (County & State, or foreign country) FROSTBURG, MARYLAND	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH PARISE	
14. MOTHER'S MAIDEN NAME CONCATTI CRIVARO		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO N.A.	
16 SOCIAL SECURITY NO 215-16-4729		17 INFORMANT MISS MARY PARISE, 85 E. MAIN ST.,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 260X cerebral ischemia. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized atherosclerosis. (c) Diabetes mellitus.		INTERVAL BETWEEN ONSET AND DEATH 10 days 10 yrs 12 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of Jejunum, post operative		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from Nov. 17, 1967 to Nov. 28, 1967 , that (I) (was) last saw the deceased alive on Nov. 28, 1967 , and that death occurred at 2:24 AM , from causes and on the date stated above.			
22a SIGNATURE Alvin J. Walters		22b. DATE SIGNED Nov 29, 1967	
22c. PHYSICIAN'S NAME (Type) ALVIN J. WALTERS, M.D.		22d. ADDRESS 48 BROADWAY, FROSTBURG, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11/30/67	23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY	23d. LOCATION (City or Town) (County) (State) FROSTBURG, MARYLAND
24 FUNERAL DIRECTOR WILLOU M. SCOTERS HAFFER-SCOTERS FUNERAL		25a REC'D BY REGISTRAR DEC 4 1967	25b REGISTRAR'S SIGNATURE J. Charles Judge

14742

CERTIFICATE OF DEATH

14752

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 31 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS 363 BEDFORD ST., CUMBERLAND	
3 NAME OF DECEASED First Middle Last ALETHEA C PARISH (Type or print)		4 DATE OF DEATH Month Day Year NOVEMBER 19 19 67	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/17/95
9 AGE (in years last birthday) 72 yrs		F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11 BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME OTTO HAER		14 MOTHER'S MAIDEN NAME ANNIE KOHL	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 214-07-0380B	
17 INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <i>1-27</i>
PART II. EITHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cor & Left Heart Disease (arteriosclerosis)</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MED. CAL. EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II for Part I of item 18.)	
20c. TIME OF INJURY Month Day Year Hour : m p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street off ca bldg, etc)	20f. (City or town) (County) (State) <i>Cumbrld Alleg Md</i>
21. I certify that (I) (this hospital) attended the deceased from <i>4/2/62</i> 19 to <i>11/19/67</i> 19 that (I) (we) last saw the deceased alive on <i>11/16/67</i> and that death occurred at <i>4:15 AM</i> from causes and on the date stated above.			
22a. SIGNATURE <i>R. J. Williams</i>		22b. DATE SIGNED <i>11/19/67</i>	
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22d. ADDRESS 122S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/22/1967	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland Alleg Md.
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REGISTRAR NOV 21 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If city delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DWR-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 N. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14744

14753

1 PLACE OF DEATH a COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c LENGTH OF STAY IN b Years	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 13 Decatur Street		d STREET ADDRESS 13 Decatur Street	
3 NAME OF DECEASED (Type or print) First Middle Last Ada Bell Parker		4 DATE OF DEATH Month Day Year November 29 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 27, 1879
9 AGE (In years past birthday) 88 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia	
13 FATHER'S NAME Henry Clem		14 MOTHER'S M A DEN NAME Alice Dawson	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO	
17 INFORMANT Cumberland City Police Department		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4a01 Coronary Occlusion DUE TO (b) Coronary Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 1 of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 29, 1967 Address (Street city town or county) Cumberland, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 12/3/1967	23c NAME OF CEMETERY OR CREMATORY Camp Hill Cemetery	23d LOCATION City, Town, (County) (State) Near Paw Paw Hampshire WVA
24. FUNERAL DIRECTOR John J. Hafer, Jr. Address 230 Balto Ave. Cumberland, Md		25a REC'D BY REG. CLERK DEC 4 1967 25b REGISTERED John J. Hafer, Jr.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

(M)

14745

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14754

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE PENNSYLVANIA b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS 9 HRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS R. D. 1, ADDISON	
3. NAME OF DECEASED (Type or print) First BABY Middle GIRL Last PEARY		4. DATE OF DEATH Month NOVEMBER Day 7 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-4-67
9. AGE (n years lost birthday) yrs 2		IF UNDER 1 YEAR Months 2 Days 9 Min 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MEYERSDALE, PA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PAUL JAMES PEARY		14. MOTHER'S MAIDEN NAME ALICE NICHOLSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 1100 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumaturity DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 4:10 AM from causes and on the date stated above.			
22a. SIGNATURE Robert Brodell M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. ROBERT BRODELL		22d. ADDRESS 500 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 9 1967	
23c. NAME OF CEMETERY OR CREMATORY Addison		23d. LOCATION (City or Town) (County) (State) Addison Somerset PA	
24. FUNERAL DIRECTOR H. Lee Silcox		25a. REC'D BY REGISTRAR NOV 13 1967	
ADDRESS 404 Decatur St. Cumb. Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15
25M 1-67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
14746			
CERTIFICATE OF DEATH			
14755			
1 PLACE OF DEATH a COUNTY ALLEGANY b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c LENGTH OF STAY IN 1b 49 DAYS d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, d STREET ADDRESS 126 VIRGINIA AVE., e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First JOSEPH Middle H. Last PENROD		4 DATE OF DEATH Month NOVEMBER Day 18 Year 1967	
5 SEX MALE 6 COLOR OR RACE WHITE 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8 DATE OF BIRTH 9-25-1897 9 AGE (In years last birthday) 70 yrs. IF UNDER 1 YEAR Months Days Hours Min		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk 10b KIND OF BUSINESS OR INDUSTRY Railroad 11 BIRTHPLACE (County & State or foreign country) CUMBERLAND, MD. 12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME GEORGE H. PENROD		14 MOTHER'S MAIDEN NAME GERTRUDE DEAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL @ CUMBERLAND, MD.	
17. INFORMANT MEMORIAL HOSPITAL @ CUMBERLAND, MD.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of pancreas & metastases INTERVAL BETWEEN ONSET AND DEATH 6 months 151X DUE TO (b) Obstructive Jaundice 1 1/2 mos Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Loenec's Cirrhosis years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (city or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/30 , 19 67 , to 11-18 , 19 67 , that (I) (we) last saw the deceased alive on 11/18 , 19 67 , and that death occurred at 7:40 AM , from causes and on the date stated above			
22a. SIGNATURE Andrew Stasko M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED MD.	
22c. PHYSICIAN'S NAME (Type) DR. ANDREW STASKO DR. XXXXXXXXXX		22d. ADDRESS 401 DECATUR ST., CUMBERLAND 236 XXXXXXXXXX	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 20, 1967	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR NOV 22 1967 25b. REGISTRAR'S SIGNATURE [Signature]	

14747

CERTIFICATE OF DEATH

14756

1 PLACE OF DEATH a. COUNTY Allegany County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN lb 89 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 622 Elm Street e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie M. Peters		4. DATE OF DEATH Month November Day 4 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/2/1878
9. AGE (In years and birthday) 89 yrs		10. IF UNDER 1 YEAR Months 11 Days 24 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Maryland	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Frost		14. MOTHER'S MAIDEN NAME Mary Drewnoski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-54-6543	
17. INFORMANT Harvey F. Peters		Address 613 N. Second Street LaVale, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial insufficiency 4 + 100 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized Arteriosclerosis DUE TO arteriosclerosis (c) Chl. A.B.H.D. DUE TO arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 35 minutes many years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from SEP 28, 1965 , 19 to Nov. 4, 1967 , that (I) (we) last saw the deceased alive on Nov. 3, 1967 , and that death occurred at 11:00 A.M. from causes and on the date stated above.			
22a. SIGNATURE John A. Tepper		22b. DATE SIGNED Nov 7 - 1967	
22c. PHYSICIAN'S NAME (Type) John A. Tepper MD		22d. ADDRESS Memorial Hospital Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-6-67	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland
24. FUNERAL DIRECTOR Silcox		25a. REC'D BY REGISTRAR 404 Decatur Street, Cumb. Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE NOV 7 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/66

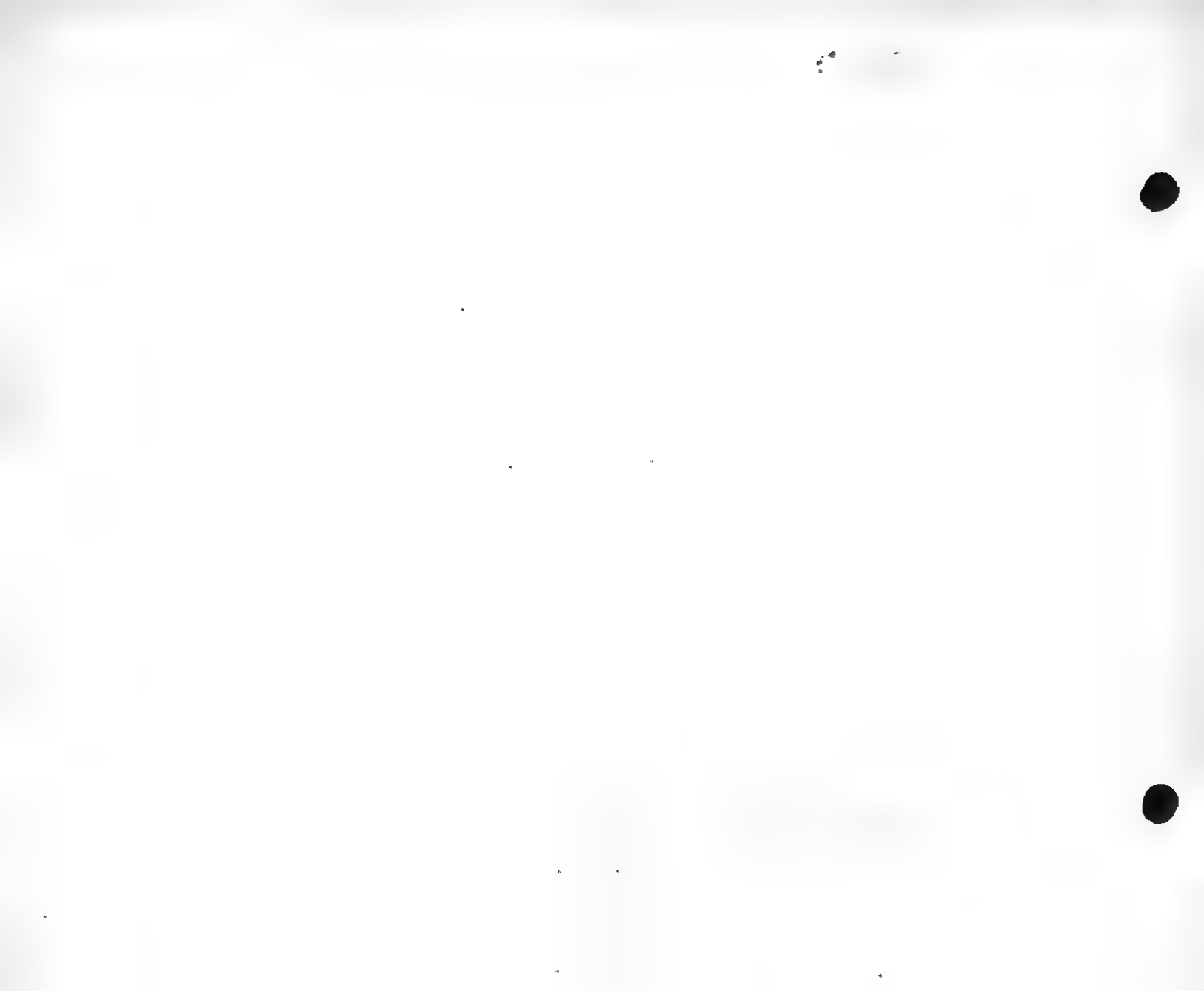
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14748

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14757

1 PLACE OF DEATH a COUNTY Allegany MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Frostburg			c LENGTH OF STAY IN 1b D O A		c CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Frostburg		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital				d STREET ADDRESS 62 Aspinall Street		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Catherine Cecilia Pfaff				4 DATE OF DEATH Month Day Year November 25 19 67			
5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 6/ 4/1912	
9 AGE (In years last birthday) 55 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Home		11 BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U S A				13 FATHER'S NAME Benjamin Quinn			
14 MOTHER'S MAIDEN NAME Barbara Knapp				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) No			
16 SOCIAL SECURITY NO 215-26-9578				17 INFORMANT G. Robert Pfaff			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5/21 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Peritonitis, generalized (c) Ruptured diverticulum of Sigmoid							INTERVAL BETWEEN ONSET AND DEATH days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c TIME OF INJURY Month Day Year hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22. DATE SIGNED November 25, 1967				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial				23b DATE THEREOF 11/29/1967		23c NAME OF CEMETERY OR CREMATORY Eckhart Methodist Cemetery	
23d LOCATION (City or town) (County) (State) Alleg Md.				23e ADDRESS Alleg Md.			
24 FUNERAL DIRECTOR John J. Hafer, Jr., 280 Baltimore Ave., Cumberland				25a REC'D BY REG. STRAR NOV 29 1967			
25b REGISTRAR'S SIGNATURE Charles Judge							



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14749

14758

1. PLACE OF DEATH a COUNTY Allegheny MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Allegheny	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c LENGTH OF STAY IN b R-F-D- Frostburg, Md.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First George Middle W. Last Poland		4 DATE OF DEATH Month 11 Day 26 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10/30/1879
9 AGE (in years last birthday) 88 yrs		10 IF UNDER 1 YEAR Months 11 Days 26 Hours 00 Min 00	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Barton, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Manuel Poland		14 MOTHER'S MAIDEN NAME Nancet Clark	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT Mrs. Martha Glime, Frostburg, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO (b) Chronic Myocarditis DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3-4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of right hip		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH Fell at home		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour 11:00 am Nov. 17 19 67		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office, playground, etc.) Home		20f (City or town) (County) (State) Rt. 1 Frostburg, Alleg. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		22. DATE SIGNED XX November 26, 1967	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER XX Address (Street, city, town, or county) Cumberland, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 11/28/1967	23c NAME OF CEMETERY OR CREMATORY Memorial Park	23d LOCATION (City or town) (County) (State) Frostburg, Md.
24. FUNERAL DIRECTOR George Eichhorn		25a REC'D BY REGISTRAR NOV 28 1967	
ADDRESS Lonaconing, Md.		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

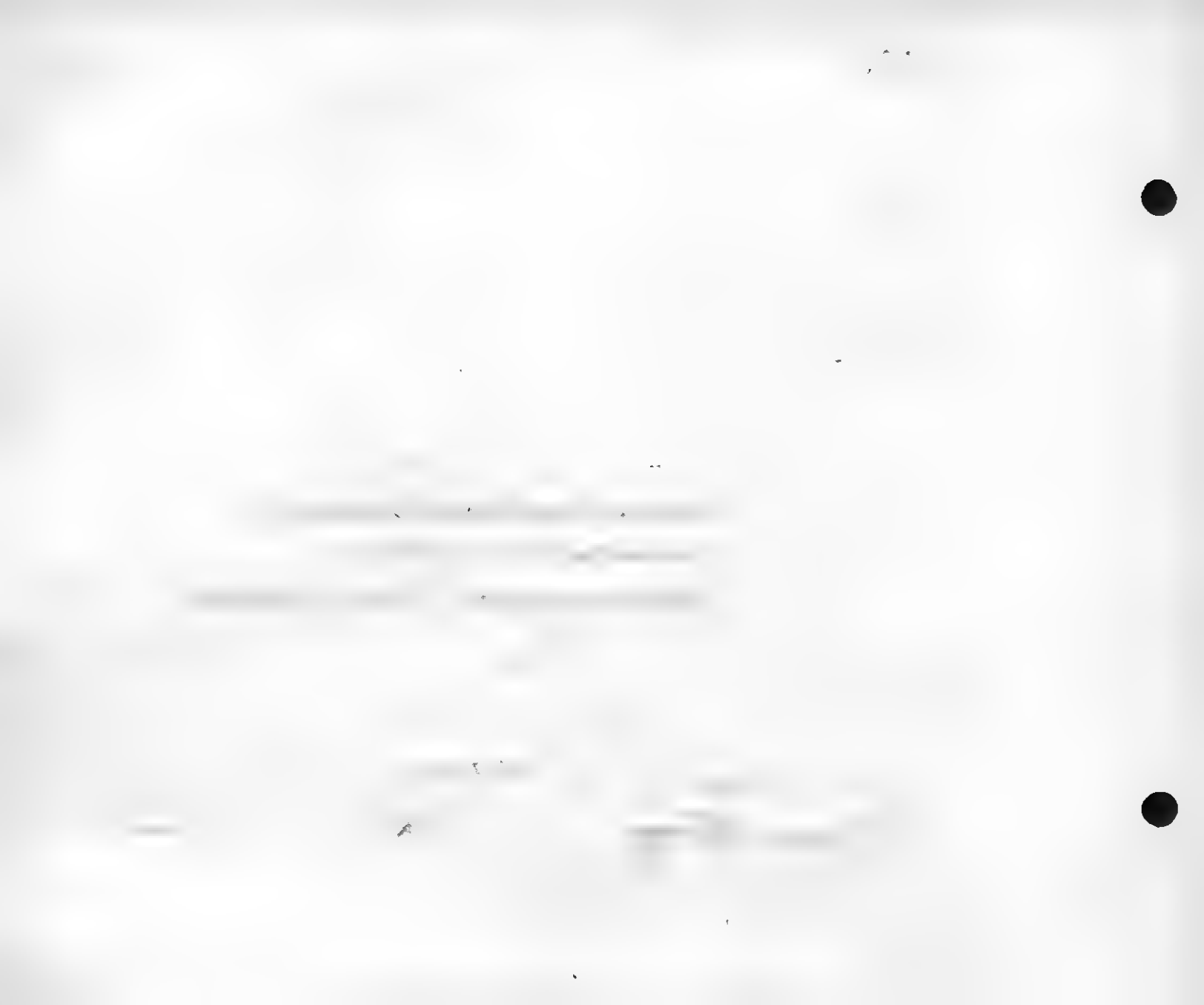
14750

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #G394 11/8/67 ph

14759

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN lb LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 189 ORMOND STREET		d. STREET ADDRESS 189 ORMOND STREET	
3. NAME OF DECEASED (Type or print) First JAMES Middle H. Last POTTER		4. DATE OF DEATH Month NOVEMBER Day 2, Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 1, 1888
9. AGE in years 79 last birthday 78 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MINER		10b. KIND OF BUSINESS OR INDUSTRY COAL MINES	
11. BIRTHPLACE (County & State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM PORTER		14. MOTHER'S MAIDEN NAME SARAH MATTHEWS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-10-2712-T	
17. INFORMANT MRS. HAZEL KEEDY, FROSTBURG, MD.		Address 21532	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADVANCED MYOCARDIAL DISEASE AND DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) COMPLETE A-V BLOCK DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE			INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct. 23, 1967 , to Nov. 2, 1967 , that (I) (we) last saw the deceased alive on Nov. 1, 1967 , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE G. Paige Strong		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Nov. 2, 1967
22c. PHYSICIAN'S NAME (Type) A. PAIGE STRONG, M. D.		22d. ADDRESS 167 E. MAIN ST., FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF NOV. 4 '67	23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY	23d. LOCATION (City or Town) (County) (State) ECKHART, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		25a. REC'D BY REGISTRAR DATE NOV 6 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge



14751

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

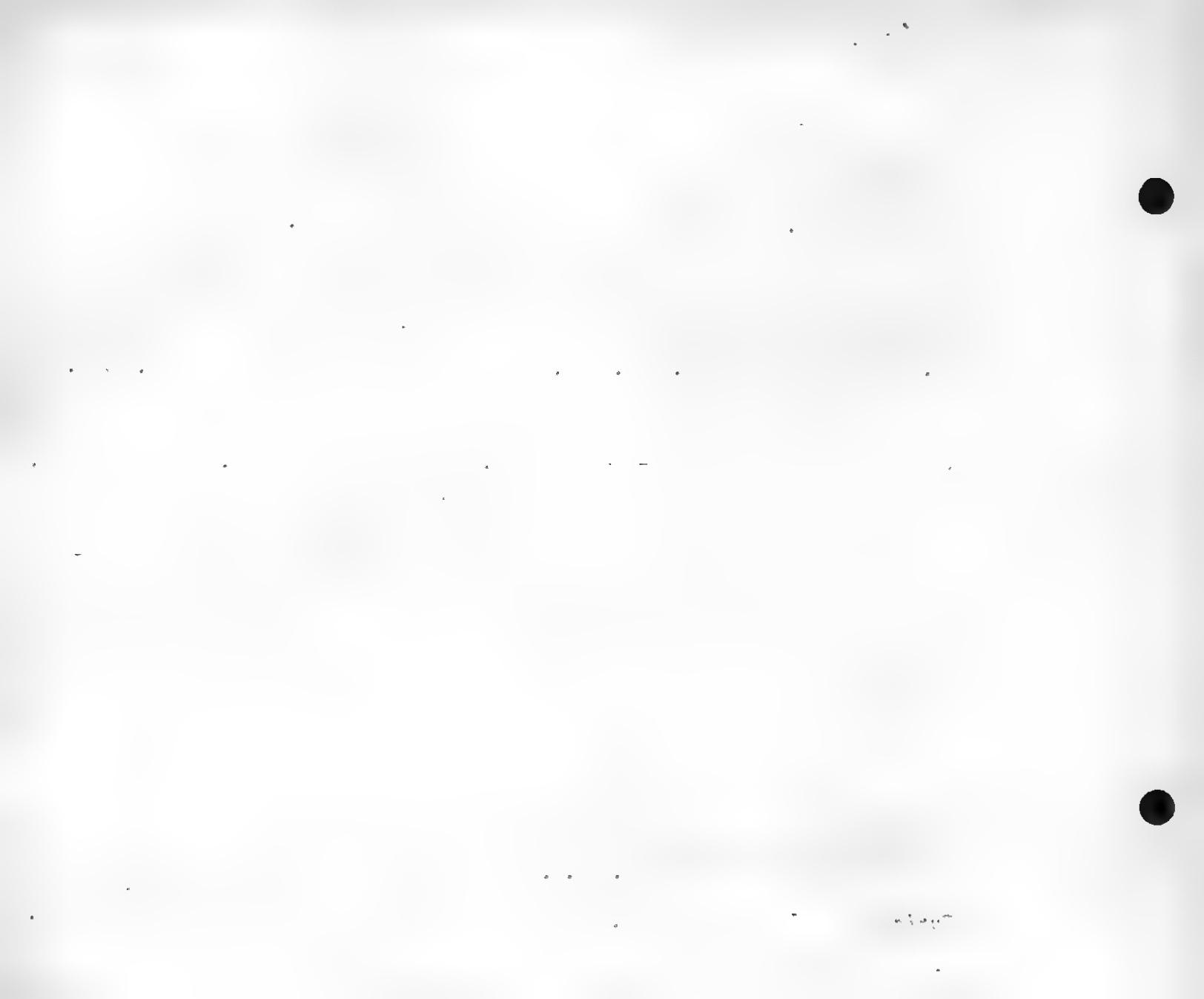
14780

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>233 Glenn St.</u>		d. STREET ADDRESS <u>233 Glenn St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>James</u> Last <u>Pou</u>		4. DATE OF DEATH Month <u>November</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25, 1889</u>
9. AGE (In years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Carman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. Rwy.</u>	
11. BIRTHPLACE (State or foreign country) <u>Gibraltar, Spain</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Alberto Pou</u>		14. MOTHER'S MAIDEN NAME <u>Julia Rotundo</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>705-09-9004</u>	
17. INFORMANT <u>Mrs. Ann Pou</u>		Address <u>233 Glenn St. Cumberland, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		CORONARY OCCLUSION CORONARY SCLEROSIS INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> -----	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		22. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county) <u>CUMBERLAND, MARYLAND</u>	
23a. BURIAL CREMATION <u>Burial</u>	23b. DATE THEREOF <u>11/28/67</u>	23c. NAME OF CEMETERY OR REMATORY <u>SS. Peter & Paul Cemetery Cumberland, Allegheny Md.</u>	
24. FUNERAL DIRECTOR <u>H. Wayne George Cumberland, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 29 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

FOR STATE
HEALTH DEPT.

14752

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14761

1 PLACE OF DEATH a COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if inst. tut on Residence before adm ssion) a STATE Maryland b. COUNTY Allg.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
c. LENGTH OF STAY IN 1b 15 years			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D. O. A. Memorial Hospital		d STREET ADDRESS 45 Main St., Potomac Park	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Burr Middle William Last Powell		4 DATE OF DEATH Month Nov. Day 6 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 15, 1906 9 AGE (In years last birthday) yrs 61
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Bus Driver		10b KIND OF BUSINESS OR INDUSTRY Public Transit	11 BIRTHPLACE (State or foreign country) Higginsville, W. Va.
12 CITIZEN OF WHAT COUNTRY? USA			
13 FATHER'S NAME Charles Powell		14. MOTHER'S MAIDEN NAME Estella Powers	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Hazel Powell, Potomac Park, Wife		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden ---	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of form 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D. EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Nov. 6, 1967 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Rt. 9 Cumberland Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Nov. 8, 1967	23c NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE NOV 8 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-102. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14753

14762

1. PLACE OF DEATH a COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE W. Va. b COUNTY Mineral			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c LENGTH OF STAY (If in institution) ?		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgeley		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Memorial Hospital				d STREET ADDRESS Carpenters Addition		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Harry Last Powell				4. DATE OF DEATH Month Nov. Day 15 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 5, 1909	
9. AGE (In years last birthday) 58 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Worker		10b. KIND OF BUSINESS OR INDUSTRY Tire Industry		11. BIRTHPLACE (State or foreign country) Augusta, W. Va.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James H. Powell				14. MOTHER'S MAIDEN NAME Virginia Saville	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Richard D. Powell, Wiley Ford, W. Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Coronary Sclerosis DUE TO (c) ---							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> , Inspected <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							22. DATE SIGNED
ACTUAL SIGNATURE Benedict Skitarelic		EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 11-15-1967	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Rt. 9 Cumberland					
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 18, 1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION (City or town) (County) (State) Augusta, W. Va.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE NOV 22 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

14754

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14763

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONA CONING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART		e. STREET ADDRESS 7 CHURCH STREET	
3 NAME OF DECEASED (Type or print) MARY First FRANCES Middle ROONEY Last		4 DATE OF DEATH Month 11 Day 23 Year 1967	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-26
9 AGE (In years, last birthday) 41 yrs		10. IF UNDER 1 YEAR Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10b. KIND OF BUSINESS OR INDUSTRY HEALTH DEPT.	
11 BIRTHPLACE (County & State or foreign country) ALLEGANY COUNTY, MARYLAND		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME LAWRENCE ROONEY		14. MOTHER'S MAIDEN NAME MARGARET (FLYNN)	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-24-6586	
17. INFORMANT HOSPITAL RECORD, SETON DRIVE, CUMB., MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 7545 DUE TO CONGESTIVE HEART FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO CONGENITAL VALVULAR HEART DISEASE (c)		INTERVAL BETWEEN DEATH AND DEATH 41 WEEKS 41 YEARS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) MARFAN'S SYNDROME			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-5-65 to 11-23-67, that (I) (we) last saw the deceased alive on 19, and that death occurred at 7P M, from causes and on the date stated above			
22a. SIGNATURE R. W. BALLIN, M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) R.W. BALLIN, M.D.		22d. ADDRESS 62 GREENE ST. CUMBERLAND, MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/27/1967	23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery	23d. LOCATION (City or Town) (County) (State) Lonaconing, Md.
24 FUNERAL DIRECTOR George Eichhorn		25a. REC'D BY REGISTRAR NOV 27 1967	
25b. REGISTRAR'S SIGNATURE		25c. ADDRESS	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14755

CERTIFICATE OF DEATH

14764

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 2 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRESAPTOWN d. STREET ADDRESS BOX 161 MEADOW VIEW DR. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHRISTOPHER ALLEN SHEPHERD First Middle Last		4. DATE OF DEATH NOVEMBER 28, 1967 Month Day Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-26-67
9. AGE (In years, months and days) 2 DAYS		10. IF UNDER 1 YEAR Months Days	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, or retired) INFANT		11b. KIND OF BUSINESS OR INDUSTRY ----	
12. BIRTHPLACE (County & State or foreign country) CUMBERLAND, MD.		13. CITIZEN OF WHAT COUNTRY? U. S. A.	
14. FATHER'S NAME LOUIS A. SHEPHERD		15. MOTHER'S MAIDEN NAME CAROL L. RIGGLEMAN	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) ---		17. SOCIAL SECURITY NO ---	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7735 Respiratory Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Pneumonia (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 194:55 P.M. , 19 67 , that (I) (we) lost saw the deceased alive on 19 , and that death occurred at 19 M, from causes and on the date stated above.			
22a. SIGNATURE DR. ROBERT BRODELL M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. ROBERT BRODELL		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 11/30/67	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.		25a. REC'D BY REGISTRAR DEC 4 1967 DATE	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 7 pages and 7 pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14756	14765
CERTIFICATE OF DEATH					
1 PLACE OF DEATH a COUNTY ALLEGANY MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c LENGTH OF STAY IN TB 18 HRS.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL			d STREET ADDRESS 711 MONTGOMERY AVE.,		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) MARY VIRGINIA First Middle Last			4 DATE OF DEATH NOVEMBER 17, 19 67. Month Day Year		
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-23-1913	9 AGE (In years last birthday) 53 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Own Home		11 BIRTHPLACE (County & State, or foreign country) MARYLAND CUMBERLAND	
12 CITIZEN OF WHAT COUNTRY U.S.A.			13 FATHER'S NAME WILLIAM GARRETT		
14 MOTHER'S MAIDEN NAME MYRTLE HECK			15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		
16 SOCIAL SECURITY NO. 213-40-3674			17 INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lymphatic Leukemia DUE TO Intestinal Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia R. Lung (c) 1 day 2 days					INTERVAL BETWEEN ONSET AND DEATH 1 day 2 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
21a TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		21b INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		21c PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 15 , 19 67 , to Nov. 17 , 19 67 , that (I) (we) last saw the deceased alive on Nov. 17 , 19 67 , and that death occurred at 7:45 A.M. , from causes and on the date stated above					
22a SIGNATURE Clay E. Durrett M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT			22d. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Nov. 19, 1967	23c NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d LOCATION (City or Town) (County) (State) Cumberland Allegany Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.			25a REC'D BY REG. STRAR NOV 22 1967		25b REGISTRAR'S SIGNATURE John W. Jones



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

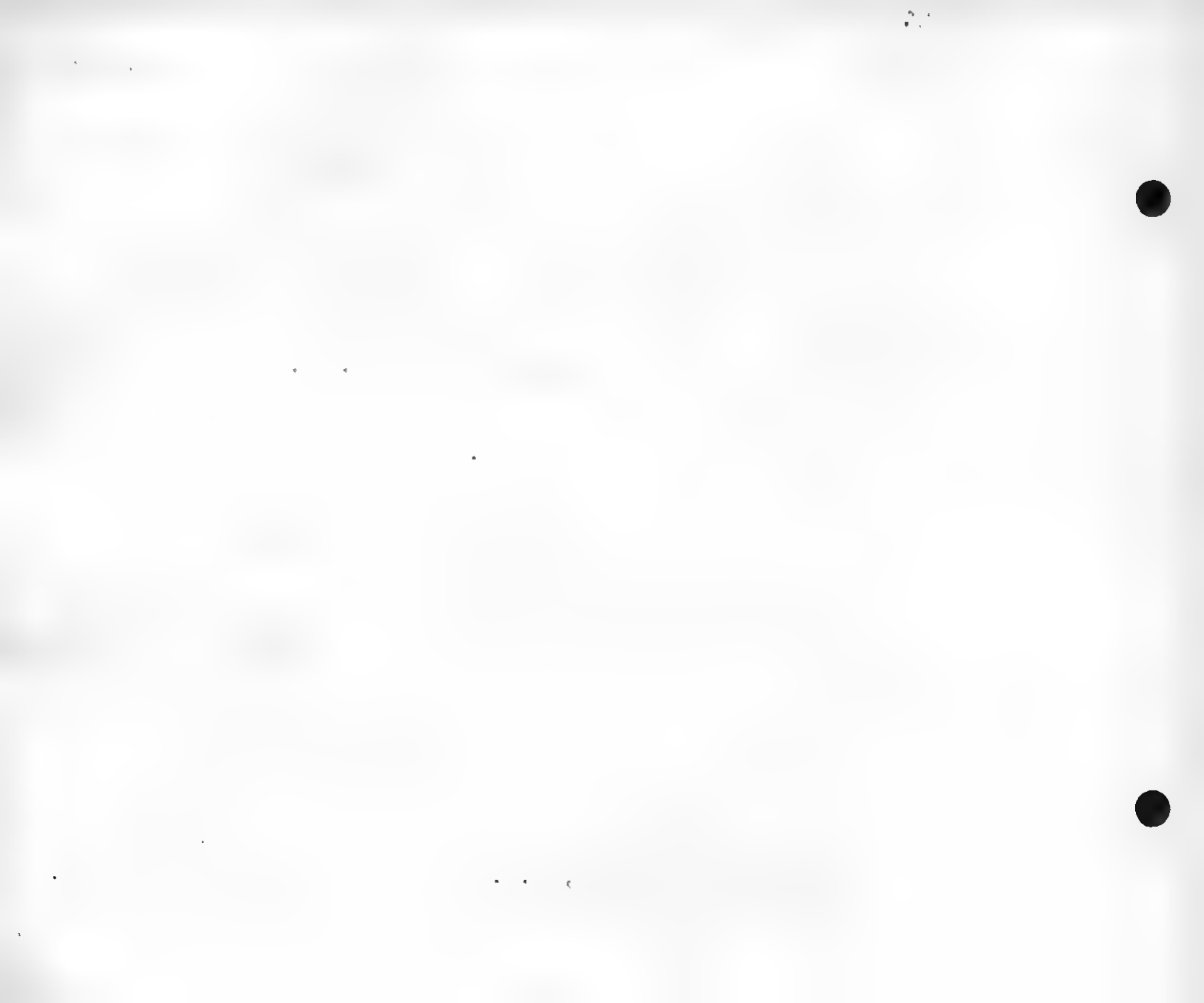
14757

14766

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN TB 36 years c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 913 Louisiana Avenue		d. STREET ADDRESS 913 Louisiana Avenue	
3 NAME OF DECEASED (Type or print) First Peter Middle William Last Smith		4 DATE OF DEATH Month Nov. Day 24 Year 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 27, 1917
9 AGE (In years last birthday) 50 yrs		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Mins 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11 BIRTHPLACE (State or foreign country) Thoms, W. Va.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Frank Smith		14 MOTHER'S MAIDEN NAME Ruby Bergstrom	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO	
17 INFORMANT Mrs. Diane Smith, Cumberland, Md. Wife		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: Coronary Occlusion Tau IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Coronary Sclerosis DUE TO (c) ---		INTERVAL BETWEEN DEATH AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour am 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
REMAINS TAKEN TO ANATOMICAL BOARD UNIVERSITY OF MD. BALTIMORE, MD.			
24. FUNERAL DIRECTOR James P. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR NOV 27 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14767

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND ALLEGANY b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 12 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 314 COLUMBIA STREET	
3 NAME OF DECEASED (Type or print) First HELEN Middle V. Last STAPLETON		4. DATE OF DEATH Month 11 Day -07 Year 19 67	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-9-87
9a AGE (in years, last birthday) 80 80 yrs		9b IF UNDER 1 YEAR Months Days Hours Min	
10a US AL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) WESTERNPORT, MARYLAND		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN Mc Partland		14. MOTHER'S MAIDEN NAME MARY (HALFPENNY)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-05-6181	
17. INFORMANT HOSPITAL RECORD - 200 SETON DRIVE, CUMB.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) APLASTIC ANEMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 YEAR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) CORONARY INSUFFICIENCY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 5 - 20 , 19 67 , to 11 - 7 , 19 67 , that (I) (we) last saw the deceased alive on 11 - 7 , 19 67 , and that death occurred at 8P M, from causes and on the date stated above.			
22a SIGNATURE R.W. Ballin		22b DATE SIGNED 11-9-67	
22c. PHYSICIAN'S NAME (Type) R.W. BALLIN, M.D.		22d. ADDRESS 62 GREENE ST., CUMB., MD. 21502	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Nov. 10, 1967	
23c NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cemetery		23d LOCATION (City or Town) (County) (State) Cumberland Allegany Md.	
24. FUNERAL DIRECTOR JAMES SCARPELLI		25a REC'D BY REGISTRAR NOV 13 1967	
ADDRESS 108 VA. AVE. CUMB. MD		25b REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

14758

14758

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers on pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS 2 HRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS 1110 FREDERICK STREET	
3 NAME OF DECEASED (Type or print) First MERNIE Middle Last STEINLA		4 DATE OF DEATH Month NOVEMBER Day 15 Year 67	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8-13 04
9 AGE (In years lost birthday) 63 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	11 IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) W. VA., Petersburg		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE C. OURS		14. MOTHER'S MAIDEN NAME FLORENCE KISAMORE	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 215-48-0225	
17 INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Terminal malnutrition and cardiac failure DUE TO (b) Scleroderma, generalized, w/ 1. heart most involved DUE TO (c) 2 years			INTERVAL BETWEEN ONSET AND DEATH 1 month
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) A.S. Cardiovascular disease with gen. arteriosclerosis			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'o m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 18 July, 1967 to 15 Nov., 1967 that (I) (we) last saw the deceased alive on 14 Nov., 1967 , and that death occurred at 3:50 AM from causes and on the date stated above			
22a. SIGNATURE W. A. Van Ormer,		22b. DATE SIGNED 16 Nov. 67	
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-17-67	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR H. Lee Silcox		25a. REC'D BY REGISTRAR DATE NOV 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

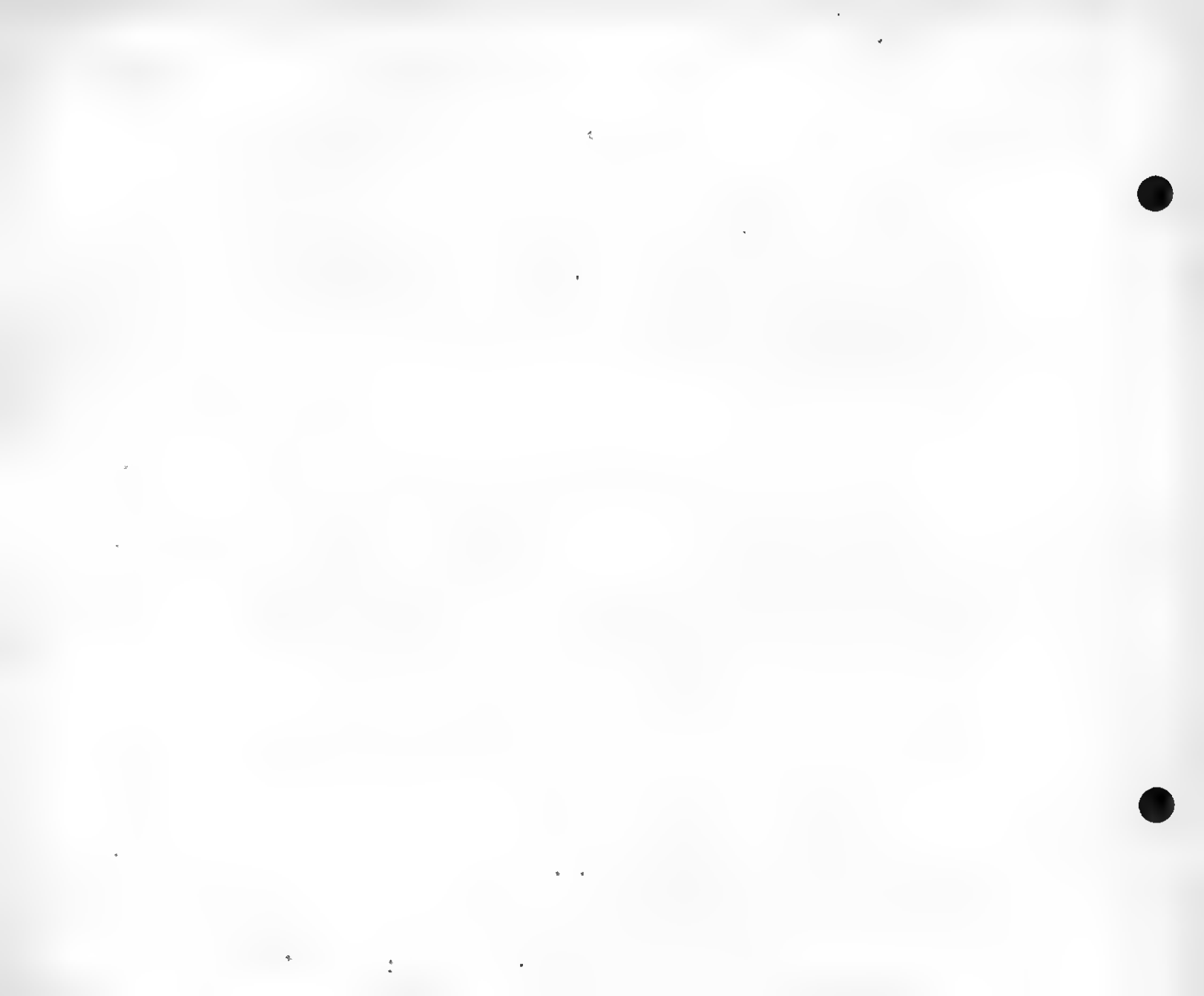
14769

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item 18. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Allegheny			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			c. LENGTH OF STAY IN 1b 01		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital, Frostburg			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) Margaret E. Stephenson			4 DATE OF DEATH Month 11 Day 25 Year 1967		
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH AUG. 16, 1887	9 AGE (in years last birthday) 80 yrs	10 UNDER 1 YEAR Months 11 Days 25 Hours 19 Min 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Bobbin room		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11 BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.			13 FATHER'S NAME Samuel Stephenson		
14 MOTHER'S MAIDEN NAME Ellen Clise			15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 215-20-6846-A		
16 SOCIAL SECURITY NO. 215-20-6846-A			17 INFORMANT John E. Stephenson, Baltimore, Md. 21234		
18 CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis, Right DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Sclerosis (c) Coronary Sclerosis					INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frostburg	(County) Allegheny	(State) Maryland
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED November 26, 1967	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Gumbarland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 28 '67	23c. NAME OF CEMETERY OR CREMATORY Fbg. Memorial Park	23d. LOCATION (City or Town) Frostburg, Md.	(County) Allegheny	(State) Maryland
24 FUNERAL DIRECTOR Joseph R. Durst, Sr., Frostburg, Md. 21532			25a. REC'D BY REGISTRAR DEC 1 1967	25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	



8 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
14761		CERTIFICATE OF DEATH	
14770			
1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 21 E. Main St., Frostburg, Md.		d. STREET ADDRESS 21 E. Main St.	
3 NAME OF DECEASED (Type or print) First Middle Last Chester Crowell Stewart		4 DATE OF DEATH Month Day Year 11/17/67	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 13, 1905
9. AGE (In years last birthday) 62		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Furniture	
11. BIRTHPLACE (County & State, or foreign country) Eckhart, Allegany Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Stewart		14. MOTHER'S MAIDEN NAME Mellie Myers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 215-10-4481	
17. INFORMANT Daughter - Sally Blane		Address Frostburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1963, to Nov 17, 1967, that (I) (we) last saw the deceased alive on 13 Nov 1967, and that death occurred at 1:40 P.M. from causes and on the date stated above.			
22a. SIGNATURE L. Michael Glick M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L. Michael Glick		22d. ADDRESS 126 N. Sunilwood St., Cumby, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-19-67	
23c. NAME OF CEMETERY OR CREMATORY WEST LAWN MEMORIAL GARDENS		23d. LOCATION (City or town) (County) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532		25a. REC'D BY REGISTRAR DATE NOV 21 1967	
		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

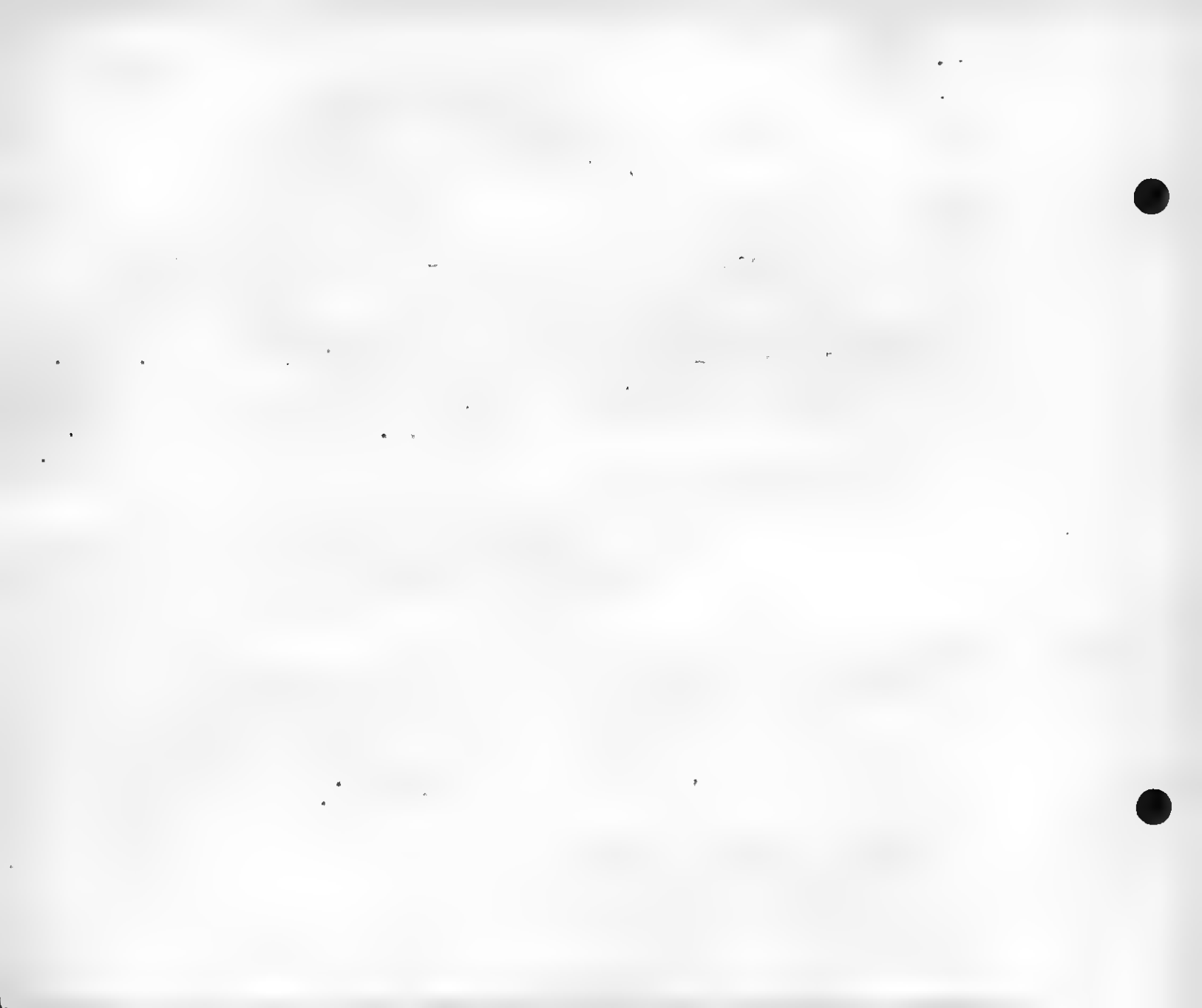
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14762

16278

1 PLACE OF DEATH a COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE Maryland b COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c LENGTH OF STAY IN TB 7/5/1967	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		d STREET ADDRESS 128 Oak Street	
3. NAME OF DECEASED (Type or print) John Michael Taylor		4 DATE OF DEATH Month November Day 28 , Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/5/1876
9 AGE (In years lost b rthday) 91 yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Blacksmith-Proprietor		10b KIND OF BUSINESS OR INDUSTRY West Virginia	
11 BIRTHPLACE (County & State, or foreign country) U. S. A.		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James William Taylor		14. MOTHER'S MAIDEN NAME Emma Florence Click	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. 21502	
17. INFORMANT P.O. Box 599, Cumberland, Md.		Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Cholesterol V. Death Arrhythmia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerosis (c) Smoking		INTERVAL BETWEEN ONSET AND DEATH approx. 1 hr years years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) P. V. D.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOT BY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Smoking	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 5, 1967 , to Nov. 28, 1967 , that (I) (we) last saw the deceased alive on Nov. 28, 1967 , and that death occurred at P. M. from causes and on the date stated above.			
22a SIGNATURE John A. Tepper		22b DATE SIGNED Nov 29, 1967	
22c PHYSICIAN'S NAME (Type) John A. Tepper		22d ADDRESS Memorial Hospital, Cumberland, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 12-1-67	
23c NAME OF CEMETERY OR CREMATORY Springfield Hill		23d LOCATION (City or Town) (County) (State) Springfield Hampshire W. Va.	
24 FUNERAL DIRECTOR Keith Schaffer		25a REC'D BY REGISTRAR DEC 7 1967	
25b REGISTRAR'S SIGNATURE Romney W. Co.		25c REGISTRAR'S SIGNATURE John A. Tepper	



14762

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Memorial Hospital 3 1/2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital 3 1/2 days		d. STREET ADDRESS 13 Arch Street	
3. NAME OF DECEASED (Type or print) First William Middle H Last Troutman		4. DATE OF DEATH Month November Day 21 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-25-1870
9. AGE (In years last birthday) 97 yrs		10. IF UNDER 1 YEAR Months 2 Days 1 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife/Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Own Home Railroad	
11. BIRTHPLACE (State or foreign country) Wheeling, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Troutman		14. MOTHER'S MAIDEN NAME Susan Robinette	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 705-05-1674	
17. INFORMANT Memorial Hospital-Cumberland, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Chronic Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Arteriosclerotic cardiovascular disease DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Months	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). Intertrochanteric fracture of Left Femur		19. WAS A JUDICIAL AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH Fell in kitchen of his home		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell in kitchen of his home	
20c. TIME OF INJURY Month, Day, Year 8:30 Nov. 18 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work Home	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cumberland, Alleg. Md.	
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		22. DATE SIGNED November 21, 1967 Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 24, 1967	
23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR NOV 27 1967	
25b. REGISTRAR'S SIGNATURE Judge			



CERTIFICATE OF DEATH

14766

14772

1. PLACE OF DEATH a COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c LENGTH OF STAY IN lb 2 DAYS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ETHEL Middle PEARL Last TWIGG		4. DATE OF DEATH Month NOVEMBER Day 17 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-1901
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN E. VALENTINE		14. MOTHER'S MAIDEN NAME MINNIE C. WILSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Massive Pulmonary Embolism with Coronary Occlusion DUE TO 2. Hypertensive Cardiovascular Disease due to (b) Arteriosclerotic Cardiovascular Disease with DUE TO Adrenal Adenoma. (c) 3. Chronic Hepatitis--Pancreatitis-Acute			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Viral Infection with dehydration and Gastroenteritis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1954 , to Nov. , 19 67 , that (I) was last saw the deceased alive on Nov. 17 , 19 67 , and that death occurred at 11:15M , from causes and on the date stated above.			
22a. SIGNATURE <i>G. Overton Himmelwright, M.D.</i>		22b. DATE SIGNED 11-18-67	
22c. PHYSICIAN'S NAME (Type) G. Overton Himmelwright, M.D.		22d. ADDRESS 133 Virginia Ave., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/21/67	
23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.	
24. FUNERAL DIRECTOR H. Wayne George		25a. REC'D BY REGISTRAR NOV 22 1967	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14765

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14773

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)

a. STATE

Maryland

b. COUNTY

Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Memorial Hospital (1 hr. 40 Min)

d. STREET ADDRESS

Route #1

e. RESIDENCE ON A FARM?
YES ☐ NO ☐

3. NAME OF DECEASED
(Type or print)

Rodger

Dale

Twigg

4. DATE OF DEATH

Month

Day

Year

November 5

1967

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒

8. DATE OF BIRTH

3-17-50

9. AGE (In years last birthday)

17 yrs

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

10b. KIND OF BUSINESS OR INDUSTRY

Ft. Hill High School

Maryland

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

C.

Harold Twigg

14. MOTHER'S MAIDEN NAME

Martha Frey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

No

16. SOCIAL SECURITY NO

None

17. INFORMANT

Memorial Hospital-Cumberland, Maryland

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Hemothorax, Right

INTERVAL BETWEEN ONSET AND DEATH

2 Hrs.

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

Compression of Chest

2 hrs.

(Automobile Accident)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

Deceased a passenger in right rear seat involved in crash

20c. TIME OF INJURY Month, Day, Year

12:10 Nov. 5 1967

20d. INJURY OCCURRED While ☐ Not While ☒ at work ☐ at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Street

20f. (City or town)

Cumberland, Alleg. Maryland

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Benedict Skitarelic

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒ November 5, 1967

DATE SIGNED

EXAMINER'S NAME (Type)

BENEDICT SKITARELIC, M.D.

Address (Street, city, town, or county) Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

Nov. 8, 1967

22c. NAME OF CEMETERY OR CREMATORY

Mt. Pleasant Cemetery

22d. LOCATION (City, town, or county)

Allegany County

(State)

Md.

23. FUNERAL DIRECTOR

John J. Hafer, Jr., 230 Balto Ave, Cumberland, Md

ADDRESS

24a. REGISTER

NOV 8 1967

24b. REGISTRAR'S SIGNATURE

Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14765

14774

1 PLACE OF DEATH a COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE PENNSYLVANIA b COUNTY ALLEGHENY ✓	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c LENGTH OF STAY IN 1b 2 DAYS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d STREET ADDRESS 10 E. MAPLEVIEW TERR.	
3 NAME OF DECEASED (Type or print) First MAUDE Middle HELEN Last WESLOW		4 DATE OF DEATH Month NOVEMBER Day 30 Year 1967	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MAY 3, 1907
9 AGE (In years last birthday) 60 yrs.		10 IF UNDER 1 YEAR Months 11 Days 24 Hours 19 Min 67	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY OWN HOME	
11 BIRTHPLACE (County & State, or foreign country) BRADDOCK, PENNSYLVANIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME FREDERICK W. CHRISTMAN		14 MOTHER'S MAIDEN NAME ANNA E. SKIDMORE	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO N.A.		16 SOCIAL SECURITY NO 194-14-6945	
17 INFORMANT MRS. JOHN VILLA		Address HOPE ROAD, FROSTBURG	
18 MARYLAND FROSTBURG			
18b CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crowning Artery Heart Disease 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH yr - yr -	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Uncontrolled Diabetes		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) X		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) X	
20c TIME OF INJURY Month, Day, Year Hour a.m. X 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X	20f (City or town) (County) (State) X
21 I certify that (I) (this hospital) attended the deceased from 11/28, 1967 , to 11/30, 1967 , that (I) (we) last saw the deceased alive on 11/30, 1967 , and that death occurred at 12:35 PM , from causes and on the date stated above			
22a SIGNATURE Martin M. Rothstein		22b DATE SIGNED 12/1/67	
22c PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN, M.D.		22d ADDRESS 48 BROADWAY, FROSTBURG, MD.	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 12/5/67	23c NAME OF CEMETERY OR CREMATORY JEFFERSON MEMORIAL CEM.	23d LOCATION (City or Town) (County) (State) ALLEGHENY CO., PA
24 FUNERAL DIRECTOR MARTIN M. SOWERS		25a REC'D BY REGISTRAR DEC 6 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

CERTIFICATE OF DEATH

14767

14775

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 10 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 233 E. MAIN ST.	
3. NAME OF DECEASED (Type or print) CHARLES C. WIEBRECHT		4. DATE OF DEATH Month NOVEMBER Day 25 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-19-06
9. AGE (in years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) SERVICE STATION MGR...		10b. KIND OF BUSINESS OR INDUSTRY SERVICE STATION	
11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MD. (ALLEGANY)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CONRAD WIEBRECHT		14. MOTHER'S MAIDEN NAME MITCHELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-09-3815	
17. INFORMANT HOSP. RECORD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Liver metastasis, Bone metastasis & Lymphoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Brachyogenic Carcinoma</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from causes and on the date stated above			
22a. SIGNATURE <u>Clarence J. Vincent</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) CLARENCE J. VINCENT		22d. ADDRESS 126 N. SMALLWOOD ST. CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11-28-67	23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY	23d. LOCATION (City or Town) (County) (State) ECKHART ALLEGANY, MD.
24. FUNERAL DIRECTOR DURST FUNERAL HOME FROSTBURG, MD.		25a. REC'D BY REG. STAFF DATE DEC 1 1967	
25b. REGISTRAR'S SIGNATURE <u>Clarence J. Vincent</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14768

CERTIFICATE OF DEATH

14776

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before adm ssion) a. STATE MARYLAND. b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN IB 39 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL 900 SETON DRIVE, CUMB., MD. 21502		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HELENA		4. DATE OF DEATH Month NOVEMBER Day 1 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-17-27
9. AGE (In years last birthday) yrs 40		10. IF UNDER 1 YEAR Months 40 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HWF.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CRESAPTOWN, MD.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME ALBERT LEASE		14. MOTHER'S MAIDEN NAME MARY CHILCOTT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-24-5795	
17. INFORMANT HOSPITAL CHART		18. ADDRESS SACRED HEART HOSPITAL 900 SETON DRIVE, CUMB., MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 157X IMMEDIATE CAUSE (a) <u>Cancer of the pancreas</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 2 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-22- 19 67 , to 11-1 19 67 , that (I) (we) ast saw the deceased alive on 11-1- 19 67 , and that death occurred at _____ M, from causes and on the date stated above			
22a. SIGNATURE L. Brings		22b. DATES SIGNED 11-2-67	
22c. PHYSICIAN'S NAME (Type) L. BRINGS, M.D.		22d. ADDRESS 57 GREENE STREET, CUMB., MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/3/1967	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md/
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REG STRAR NOV 6 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

W. J.

J.

W.

100

W.

W.

W.

J.

W.

W.

W.

J.

W.

W. J.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)
6M 1/67

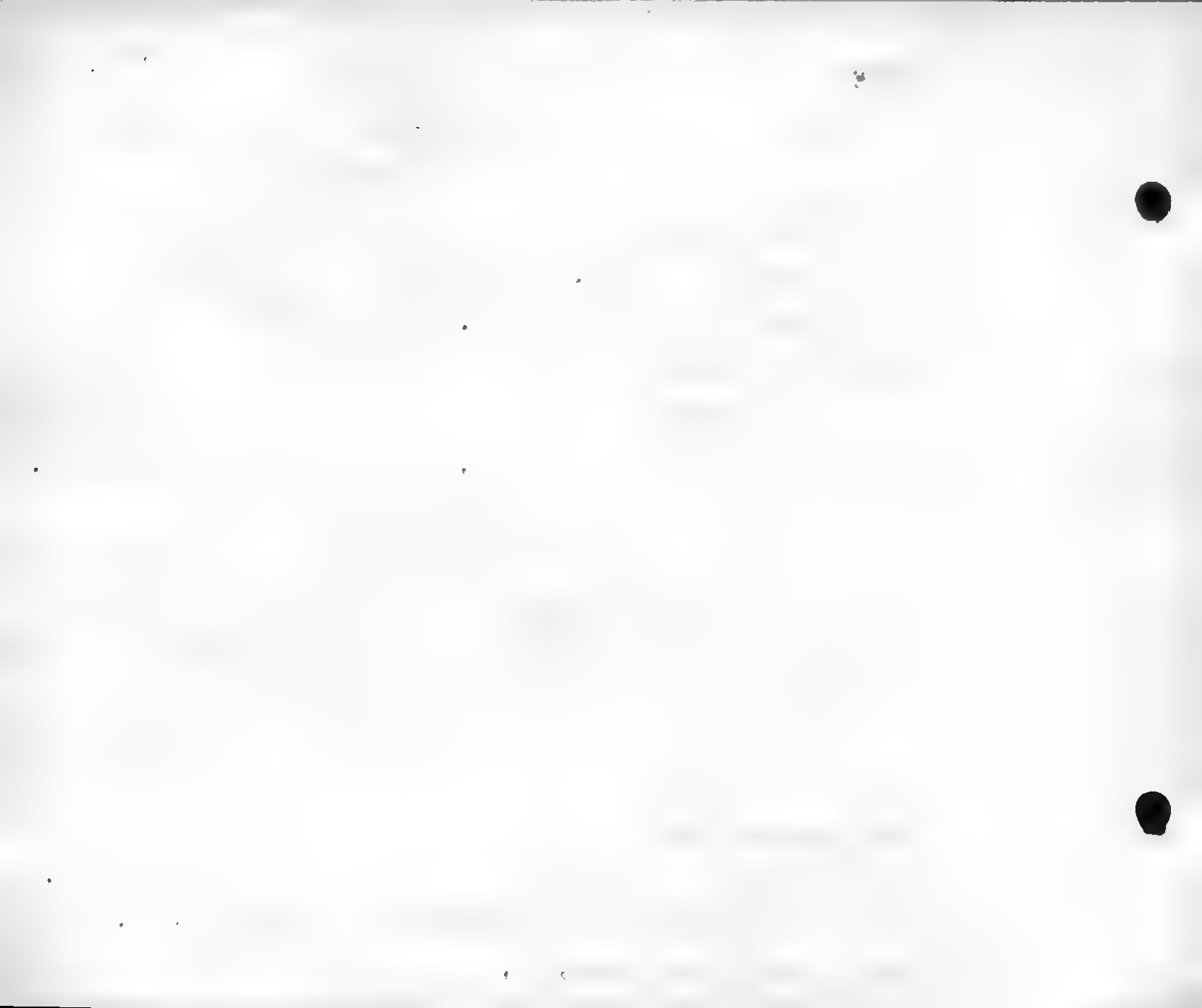
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14769

14777

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE Maryland c. COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c LENGTH OF STAY IN 1b Cumberland	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 320 Furnace Street		d STREET ADDRESS 320 Furnace Street	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Leonard D. Wilson		4 DATE OF DEATH 11/13/1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12/7/1884
9 AGE (In years last birthday) 82 yrs		F UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b KIND OF BUSINESS OR INDUSTRY England	
11 BIRTHPLACE (State or foreign country) USA		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Robert Wilson		14 MOTHER'S MAIDEN NAME Bessie Hatherley	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO	
17 INFORMANT Mrs. Kirby Miller, Cumberland, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) CORONARY SCLEROSIS (c)		INTERVAL BETWEEN DEATH AND DEATH HOURS MINUTES ----	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarolic EXAMINER'S NAME (Type) BENEDICT SKITAROLIC, M.D.		22. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/> November 13, 1967 Address (Street, city, town or county) Cumberland, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11/15/1967	
23c NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d LOCATION (City or town) (County) (State) Lonaconing, Md.	
24. FUNERAL DIRECTOR George Eichhorn, Lonaconing, Md.		25a REC'D BY REGISTRAR DATE NOV 15 1967	
25b REGISTRAR'S SIGNATURE Charles Jones			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

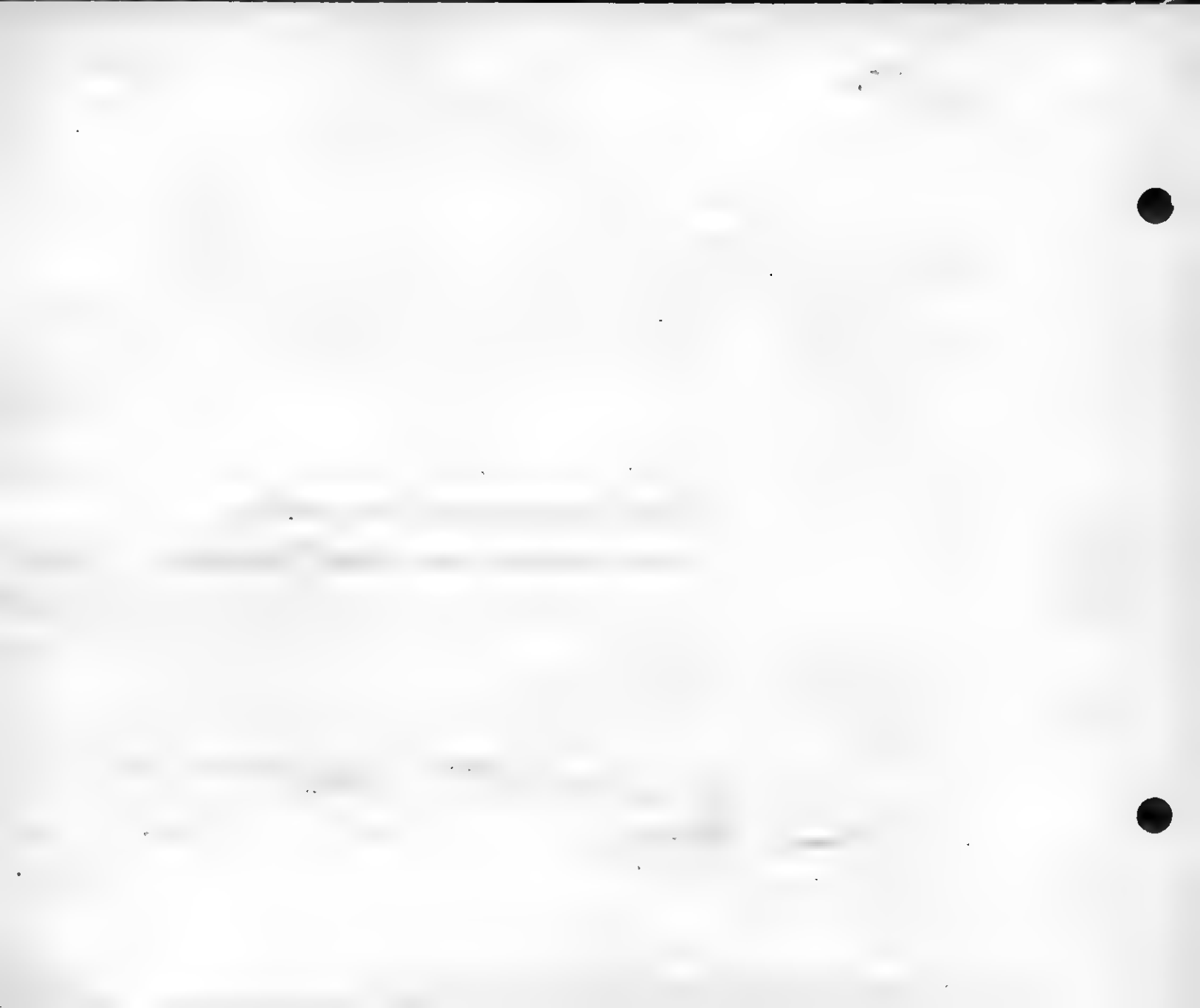
14770

14778

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FROSTBURG</u> HOURS c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MINERS HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ECKHART</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>FRANCES TRENA WRIGHT</u>			4. DATE OF DEATH <u>NOVEMBER 19, 1967</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 22, 1884</u>		9. AGE (In years last birthday) <u>83</u> yrs F UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>FROSTBURG, MARYLAND</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>HENRY PAPE</u>				
14. MOTHER'S MARDEN NAME <u>ELIZA COPPAGE</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u> <u>N.A.</u>				
16. SOCIAL SECURITY NO <u>NONE</u>			17. INFORMANT <u>MR. THOMAS WRIGHT, ECKHART MARYLAND</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <u>4201</u> IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>arteriosclerotic heart disease</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1967, to Nov 19, 1967, that (I) (we) last saw the deceased alive on Nov 18, 1967, and that death occurred at 3:24 AM, from causes and on the date stated above.							
22a. SIGNATURE <u>A. Paige Strong</u>			22b. DATE SIGNED <u>Nov. 19, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>A. PAIGE STRONG</u>		
22d. ADDRESS <u>167 EAST MAIN ST., FROSTBURG, MD.</u>			23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				
23b. DATE THEREOF <u>11/22/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ECKHART CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>ECKHART, MARYLAND</u>			
24. FUNERAL DIRECTOR <u>WALTER D. SOWERS, AFTER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG</u>			25a. REC'D BY REGISTRAR <u>DATE NOV 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 14
 20 M 1/66



14771

CERTIFICATE OF DEATH

14779

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c LENGTH OF STAY IN 1b 12 Years	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SYLVAN RETREAT		d STREET ADDRESS 921 Silbert Place	
3 NAME OF DECEASED (Type or print) First HELEN Middle WYSNER Last WYSNER		4. DATE OF DEATH Month NOV. Day 5 Year 19 67	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH ? 1892
9 AGE (In years last birthday) 75 yrs		10 IF UNDER 1 YEAR Months 1 Days 10 Hours 10 Min 10	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b KIND OF BUSINESS OR INDUSTRY none	
11 BIRTHPLACE (County & State, or foreign country) Unknown		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME JOSEPH WYSNER		14. MOTHER'S MAIDEN NAME MARGARET O'DONNELL	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 220-52-9778	
17. INFORMANT Sylvan Retreat, Cumberland, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral aneurysm DUE TO CHL. ASH & D Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last arteriosclerosis (b) arteriosclerosis (c) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH approx. 6 days many years many years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Squid		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 15, 19 67 , to Nov. 5, 19 67 that (I) (we) last saw the deceased alive on Nov. 4, 19 67 , and that death occurred at 8 P.M. from causes and on the date stated above.			
22a. SIGNATURE John A. Tepper		22b DATE SIGNED Nov 6, 1967	
22c PHYSICIAN'S NAME (Type) John A. Tepper MD		22d ADDRESS Cumberland Hospital	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 9, 1967	23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery	23d LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a REC'D BY REGISTRAR DATE NOV 10 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14780

14772

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 62 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 448 WILLIAMS STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARTHUR FREDERICK ZARGER		4. DATE OF DEATH Month NOV Day 30 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 25, 1904
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 01 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST HELPER B&O RAILROAD		10b. KIND OF BUSINESS OR INDUSTRY CUMBERLAND	
11. BIRTHPLACE (State or foreign country) CUMBERLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN ZARGER		14. MOTHER'S MAIDEN NAME KATE "CHRISTMAN" ZARGER HOPCRAFT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 705-05-5257	
17. INFORMANT LILLIAN ZARGER 448 WILLIAMS ST. CUMBERLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- (c) ---			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D. EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		22. DATE SIGNED 30 NOV 67 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3 DEC 67	23c. NAME OF CEMETERY OR CREMATORY ST. LUKES CEMETERY	23d. LOCATION (City or Town) (County) (State) CUMBERLAND ALLEGANY MD.
24. FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR STREET CUMBERLAND		25a. REC'D BY REGISTRAR DATE DEC 4 1967 25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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CERTIFICATE OF DEATH

14781

1. PLACE OF DEATH a. COUNTY Allegany County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Maryland c. LENGTH OF STAY IN 1b 81		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		d. STREET ADDRESS 619 N. Mechanic Street	
3. NAME OF DECEASED (Type or print) First Middle Last Mary E. Zink		4. DATE OF DEATH Month Day Year November 3 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/14/1886
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James McKenzie		14. MOTHER'S MAIDEN NAME Sarah (McKenzie) McKenzie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-05-8816 D	
17. INFORMANT Mrs. Pauline Moyer		Address 49 N. Mechanic Street Cumberland, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute renal insufficiency DUE TO (b) Chr. A.S.N.D. DUE TO (c) Arterio Sclerosis, Generalized many years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) R.V.D. with gangrene lower extremities			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-27 , 19 63 , to Nov 3 , 19 67 , that (I) (we) last saw the deceased alive on Nov 3 , 19 67 , and that death occurred at 6:25 PM , from causes and on the date stated above.			
22a. SIGNATURE John A. Teppen		22b. DATE SIGNED Nov 4, 1967	
22c. PHYSICIAN'S NAME (Type) John A. Teppen M.D.		22d. ADDRESS Memorial Hospital Cumberland Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-6-67	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR H. Lee Silcox		ADDRESS 404 Decatur Street, Cumb.	
25a. REC'D BY REGISTRAR NOV 7 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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